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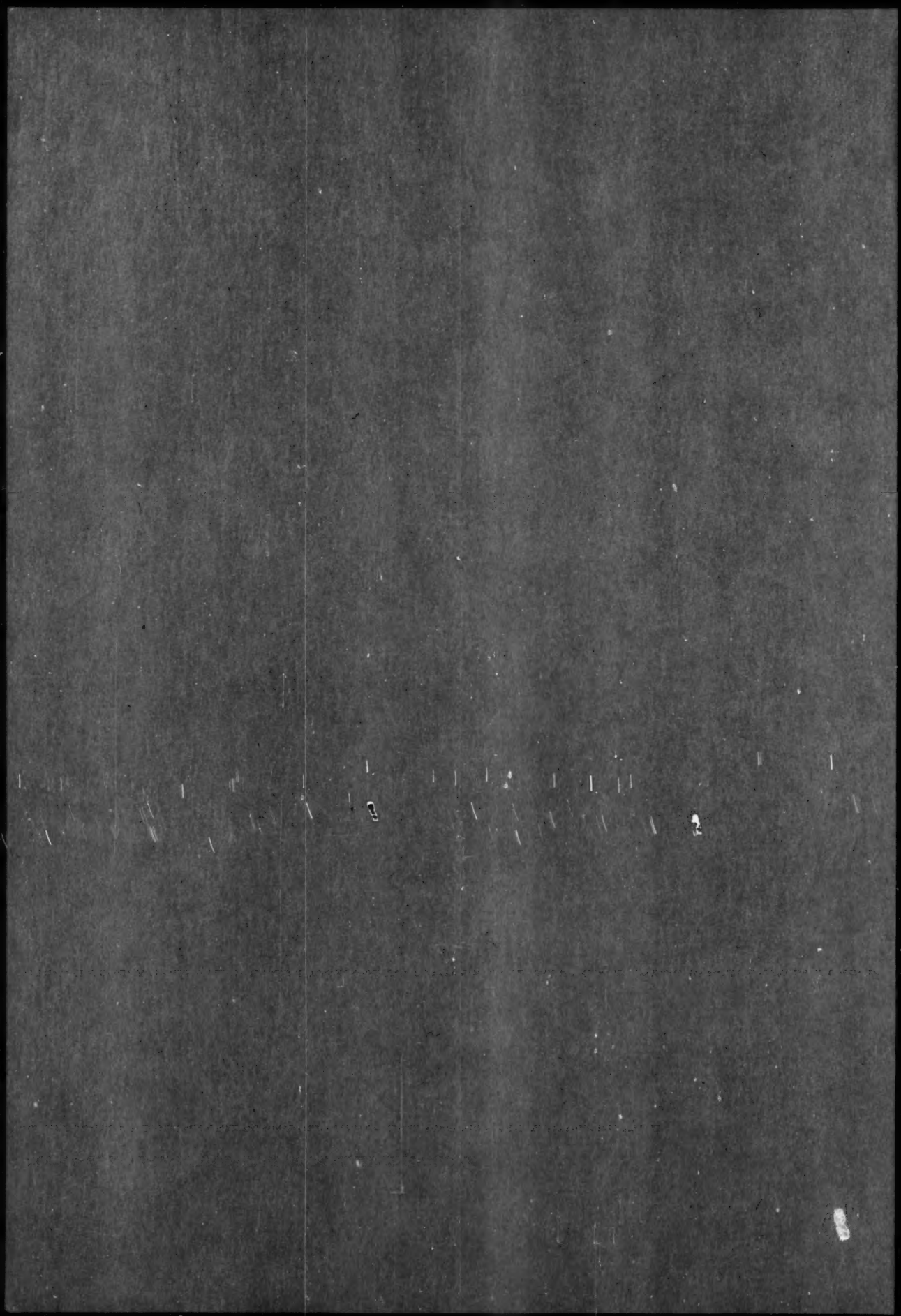

THE AMERICAN JOURNAL OF PSYCHIATRY

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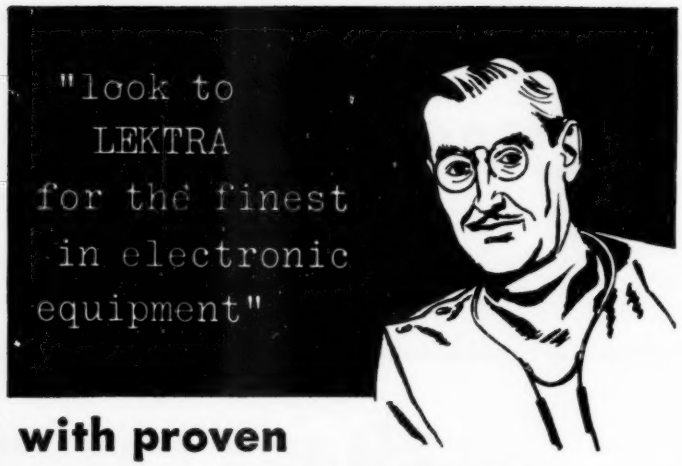

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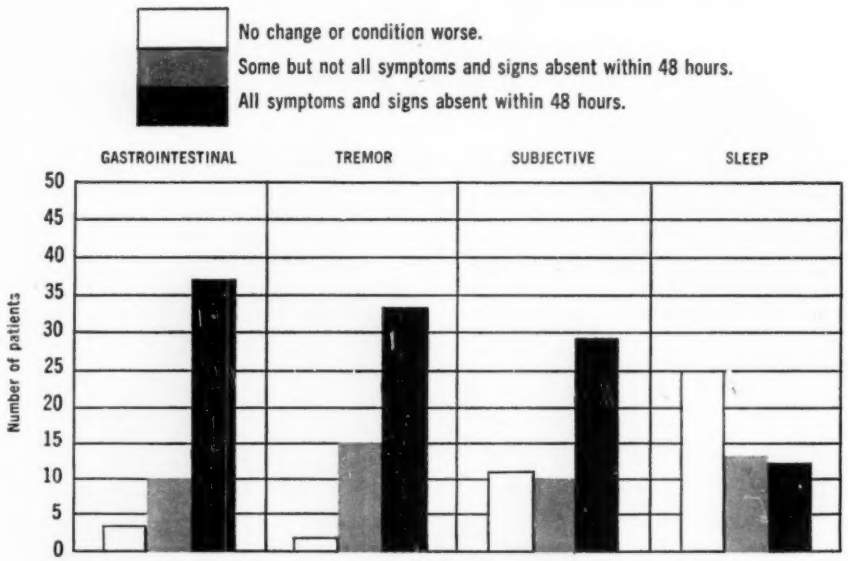

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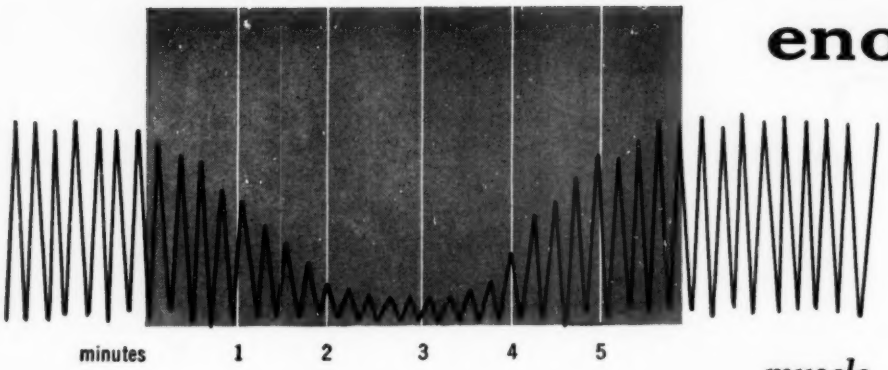

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LETTER FROM BRITAIN

AUBREY LEWIS, M.D., F.R.C.P.[1]

I am glad to comply with your invitation to write about psychiatry over here, though I cannot see it in perspective as I am too close.

"In making any survey, even the freest and loosest, of modern psychiatry, it is difficult not to take it for granted that the modern practice of the art is an improvement upon the old. With their simple tools and primitive materials, it might be said, Esquirol did well and Kraepelin even better, but compare their opportunities with ours!" Complacency and condescension—these are not agreeable attitudes. Certainly most of us take it for granted that our opportunities are greater and the modern practice better than the old, now that empirical treatment is so often dramatically potent, public understanding so much livelier, and psychotherapy so varied, intricate, and confident; but there is also a sceptical undertone evident in the passage (which I have adapted from an essay), an implied need for us to reconsider our supposed progress. Such a pause for sceptical reflection now and again may do no harm. But after the pause and the reflection, advances are still manifest, here as in other countries.

Not all the advances are clinical and scientific. Social changes have had a strong influence, mostly favourable. The idea of the Welfare State may be assailed on various grounds, but reformers, radical and conservative alike, approve the betterment in many social services (including health services) which signalise it. It has lessened social stresses which psychiatrists and psychiatric social workers judge adverse to mental health, and it has particularly favoured the growth of rehabilitation and outpatient clinics. The mental hospitals used to be pretty well self-contained, almost isolated; now they penetrate widely into the community and are anastomosed to other hospital services. The gulf between their doctors and the consultants in private practice or on the staff of teaching hospitals has been filled in and carries a lot of traffic in both directions. Both groups alike provide a domiciliary service at the request of the family doctor, and (when concerned with the same problems, *e.g.*, outpatient treatment of neuroses) may work under identical or similar conditions.

Not that we are already in the Promised Land: we have prejudices, diversity of outlook and practice, lack of enough suitable staff, variations in quality, grim old buildings, scarcity of materials, and other shortcomings incident to human affairs in 1953. But some of these obstacles and weaknesses are a heritage that we cannot disclaim; some are symptoms of the national disparity between demand and supply, which applies to human as well as material resources; almost all can reasonably be regarded as temporary troubles. If this view is unwarranted—if, for example, the occupational demand for women above a certain standard of intelligence and character should continue to be so great that we cannot recruit as many of them for mental nursing and psychiatric social work as we require—then the prospect is bleak.

The shortage of mental nurses is the most serious immediate problem we have; of possible remedies—to make mental nursing more attractive, to rationalise it so that fewer people could do the work, to modify the present standard of training and qualification—none is easy or without risk. The first might rob Peter (other essential professions) to pay Paul; the second might dehumanise mental nursing and defeat the main end of psychiatric care; the third might make the way easy for nurses who are unfit, in intellect and personality, for the work. I suppose our troubles about nursing—which affect male nurses as well as female—have their counterpart in other countries with a well-developed tradition of good nursing and a postwar difficulty in filling all their professional cadres. Maxwell Jones, in the therapeutic community which he has so ably developed and studied, has met or, rather, dodged the problem

[1] Professor of Psychiatry, University of London and physician in charge of Professional Unit, Bethlem Royal Hospital and the Maudsley Hospital.

by dispensing with trained nurses and relying on young women with a degree in social sciences. But that could not be a general solution.

Our psychiatric services for children have expanded greatly, but not enough to meet all the demands made on them. If in the 'twenties and 'thirties the pattern of child guidance had not been kept so distinct administratively, educationally, and in orientation, from the psychiatry of adults some of the present malaise might have been avoided. Child psychiatry suffers also from the unsettled state of opinion about what treatment is most effective and what grounds justify or require that a child be referred to the psychiatric clinic. Magistrates, head teachers, social workers, and even doctors have differing views; and the public is half-convinced that outwardly trivial disturbances may augur unhappiness, insanity, or crime if left untreated. It follows that in some areas more children are referred than need be, and in other areas fewer.

The university departments of psychiatry have exercised increasing influence in their regions. The number of chairs, very small before the late war, has now quadrupled; and it is almost everywhere the practice for clinical chairs in psychiatry, as in other branches of medicine, to be whole-time. Undergraduate instruction in psychiatry has consequently improved greatly in many places. The amount of time given to it at various stages of the curriculum varies from school to school, but is less than in the United States. In London, where nearly half the medical students of Great Britain are taught, their instruction in psychiatry is in the hands of part-time consultants, according to the time-honoured pattern. Most of the teachers aim at equipping a good general practitioner, though they differ somewhat about the amount and type of psychiatric help the practitioner should be able to give his patients. Very few teachers consider it their chief business to prepare the medical student for an era of great changes in psychiatry introducing new ideas which he will have to winnow. It is open to question whether such a training would be feasible and useful (I think it would); or whether psychiatry would be furthered by more ambitious programmes of undergraduate teaching, intended to give the future doctor as good a grounding in psychiatry as he now receives in neurology, as firm and flexible a grasp as he gets (if he is fortunate in his teachers) in internal medicine. So far as the London schools are concerned at present, a governing factor is time: how much time will be conceded, how much can be amicably avulsed from teachers of other subjects more securely imbedded in the curriculum. Within the time given him, the teacher has great latitude in content and method.

The position of London in these matters is distinctive also because of its special privileges and responsibilities in postgraduate medical education. After the war a number of specialist hospitals that had been engaged in teaching and research were designated, along with their accompanying medical schools, as components in a Postgraduate Federation, forming a College of the University of London which would cover every branch of medicine and surgery. This bold conception has been worked out, so far as possible, during the succeeding years, and each postgraduate medical school (or institute) with its corresponding teaching hospital has gone its own way to further its specialty. At the Institute of Psychiatry, the University has established 6 professorial chairs and readerships. Within the department of psychiatry are divisions concerned particularly with genetics, forensic psychiatry, children, medical statistics, and endocrinology; and the staff of the hospital represents a wide spectrum of clinical interests and practice. It is therefore possible for comprehensive clinical training and wide scientific activity to go on together in one institution, on a much larger scale than can at present be realised, or is likely to be realised, elsewhere in this country. In London there are furthermore such vigorous and specialised centres as the Tavistock Clinic and the Institute for Human Relations, where diverse activities in treatment, research, and furtherance of mental health in the community are pursued by a closely knit group; the Cassel Hospital for psychoanalytic treatment within a "therapeutic community"; the Belmont Industrial Neurosis Unit; the 2 analytic centres—the Institute of Psychoanalysis and the

Institute for Analytical Psychology; and many others.

Psychiatric activity outside London has been vigorous, and growth rapid. There are in England flourishing hospitals, clinics, and centres of research and teaching, especially in the large cities and university towns, notably Birmingham, Manchester, Cardiff, Bristol, Leeds, and Newcastle. Scotland remains a prolific mother and kindly nurse of psychiatrists: the great importance and influence of Edinburgh needs no stressing; in Aberdeen and Glasgow the university clinics are advancing rapidly, and the Crichton Royal Hospital, Dumfries, is a notable centre of research and clinical progress.

Graduate (or, as we call it, postgraduate) instruction has its ups and downs. For good or ill, it is rather closely related to the requirements for the Diploma in Psychological Medicine. This diploma has been to psychiatrists what a coat of arms used to be to gentlemen—a public emblem, customary, and at times necessary, but not indispensable; a source of confidence or modest pride rather than of high pretension. Heraldic devices need some interpretation: so do D.P.M.'s. Dr. Whitehorn recently pointed out, in his Academic Lecture to The American Psychiatric Association, that our diploma is not standardised: you need to know who granted it before you can be sure what it means. It nowhere sinks below a known level, but above that there are many gradations. This is true, of course, of many diplomas and many degrees in this country, where each university jealously maintains its autonomy in all things academic, and examining bodies such as the Royal Colleges likewise cling to their traditions and independence. An Edinburgh M. A. or M. R. C. P. or M. D., for example, is not the same as its London counterpart: only a partisan would say that one or other was superior, but no one would deny that they are different. This diversity is no bad thing, provided that a common minimal standard of scholarship and professional competence is maintained. Moreover, the qualifications themselves change as knowledge and circumstances require: here a particular requirement is abrogated, there a new feature grafted on or a higher standard demanded; a dissertation is substituted for one of the "vivas," questions on statistics or genetics or biochemistry are introduced, the amount of psychopathology is extended, or of neurology contracted. Some examining bodies require a candidate for the diploma to show evidence of balanced and diversified training before he may sit the final examination; others are content if he has spent a sufficient time as doctor in a mental hospital. The most stringent requirement, because the most comprehensive and balanced, is that of the University of London, which last year instituted an Academic Diploma in Psychological Medicine; this is reserved for graduate students who have received systematic clinical and theoretical training in its medical schools and laboratories. The curriculum for this Academic Diploma has much more in common with a degree course than with the preparation for most diplomas in clinical specialties, since the training extends in a planned sequence over at least 3 years, the student's teachers are among his examiners, and he is judged on his whole clinical record as well as on how he acquits himself in the final papers and the oral and clinical examinations.

Clinical teaching in Great Britain makes use of the familiar methods—the seminar, the ward round, the case discussion, the lecture, the one-way screen, the journal club, clinico-pathological sessions, and supervised psychotherapy. Some teachers labour to impart knowledge to the student, others to train him in habits of thought: the principles of group psychotherapy are applied to education in one school, and apprenticeship is the watchword in another. There are places where psychopathology according to Freud is the beginning and ending of wisdom, others where the foundations are held to lie in physiology, biochemistry, and genetics. On recently occupied ground, like group psychotherapy or human relations in industry, divergence is inevitable: Kraupl Taylor's approach, or Foulkes's, to the dynamics of group treatment, for example, differs considerably from that of Sutherland and Ezriel. But sharp contrasts and extreme positions are the exception. The teacher who urges his students to read and re-read Jaspers will be found encouraging them to seek help from social workers and clinical psy-

chologists; the synthesist of psychoanalytic and Lewinian concepts may be heard stressing the relevance of developmental brain anatomy and comparative psychology.

Treatment and investigation are much the same as in other countries with a well-developed psychiatric tradition: perhaps more soberly pursued, on the whole, and more cautiously evaluated than in the liveliest centres elsewhere, but with the same variations of emphasis on the physical and the psychological, and the same gradations of enthusiasm or scepticism, as arise everywhere from the temperament, response to novelty, and training of individual psychiatrists. Those who work in mental hospitals have more clinical independence than they used to. The medical superintendent has lost much of his former dominance; with the advent of the National Health Service his status has changed, so that he tends more and more to be engaged in clinical work on the same footing as his senior colleagues, and the influence he exerts on them derives less from his office than from his character and ability. No one now would maintain the fiction that the medical superintendent is acquainted with the clinical problems, and ultimately responsible for the treatment, of every inpatient. On the whole the medical community of the mental hospital is less nicely graded than formerly: the hierarchy has been assimilated to that of other public hospitals so that there are 2 strata—the one composed of members of the permanent senior staff, all on an equal footing, and the other consisting of junior staff who are being trained or who hold jobs that can be filled by men of modest competence in the specialty.

The place of nonmedical workers—clinical psychologists, psychiatric social workers, occupational therapists, speech therapists, and technicians of various sorts—is assured: the demand mostly exceeds the supply. Nonmedical psychotherapists on the other hand are few and have no official recognition. They are as much the subject of controversy as in the United States, though the form of the dispute is a little different since it is not as a rule our clinical psychologists who undertake or want to undertake psychotherapy.

I had intended to write at this point about lines of research. But it is already so patent that I cannot get a psychiatric map of Great Britain on a postage stamp that I will not attempt a thumbnail sketch of this extensive tract. Instead I had better refer to the latest review of current research: the composite "Prospects in Psychiatric Research" edited by Tanner. It gives a conspectus of what people here are doing and planning to do, though (as in almost all such symposia) there are notable omissions: *e.g.*, the psychological enquires of Eysenck into normal and abnormal personality; McIlwain's work on the metabolism of electrically stimulated brain tissue; and the studies of mental deficiency by Tizard and O'Connor of the Medical Research Council Unit. But, with due allowances, the book gives a picture of the trends and range of research directly relevant to psychiatry, or seeming to be so in March 1952.

A word must be said about psychoanalysis. It is less in the ascendant than in the United States. Moreover the disciples of Jung also win adherents and train them systematically. Practically all the teaching posts in the medical schools are held by men who, though they may be well-wishers, are not votaries of psychoanalysis. Thus none of the recognised teachers of psychiatry in the undergraduate medical schools of London is a member of the Psychoanalytic Society. In the largest postgraduate psychiatric centre—the Institute of Psychiatry at the Maudsley Hospital—a fifth of the senior medical staff belong to the British Psychoanalytical Society and 12 of the psychiatrists in training (June 1953) are being psychoanalysed; the Jungian view also is represented on its senior staff, and 4 trainees are having a Jungian analysis. Such diversity is in keeping with the policy of the Institute and its associated hospitals (the Maudsley and Bethlem) whereby responsible proponents of diverse views state them fairly and without heat, as in other branches of university teaching, and the pupils are free to listen, weigh, accept, reject, or modify and assimilate.

The intricacies of psychoanalytic theory, as understood in London, have been expounded in books doubtless well known in the United States, like those of Marjorie Brierley, Melanie Klein and her group, Ernest Jones, and Edward Glover—the last

writing often with polemical vigour. There are comparatively few prominent psychoanalysts outside London: this has disadvantages. Thus W. R. D. Fairbairn of Edinburgh has developed original views about object-relations and the structure of the personality; these, it has been hinted, might be less unconventional if he had lived nearer his fellow analysts and had their comments and criticism.

You suggested that I might like to mention Henry Maudsley's influence on current psychiatry. I attempted something of the sort in the Maudsley Lecture in 1950. Of course no one can trace with any sureness the effects a century later of one man's thought and work; too many other forces have been acting. But like his contemporary, Hughlings Jackson, Maudsley left an impress that cannot be gainsaid. And, like Hughlings Jackson, much of the lasting effect has been through an institution. Just as the one man's posthumous influence has depended not only on his writings and pupils but on the embodiment of some of his ideas and teachings in the National Hospital, Queen Square, so Maudsley's contribution to latter-day psychiatry might have become indistinct and slight, if there had been no hospital in Denmark Hill to carry his work forward, recasting and amplifying it as fresh knowledge and new conceptions demanded. The 5 main departments in the Institute there—clinical psychiatry, psychology, neurophysiology, biochemistry, pathology—fairly reflect his idea of how the study of mental states must be pursued and nourished within a university, and applied within a hospital.

The temper of Maudsley's mind was critical, distrustful of elaborate speculation, sceptical, candid, and tough. That these qualities are strongly manifest in English psychiatry today, I could hardly maintain, or that its philosophic standpoint is mainly positivist as his was. Any looseness in the texture of serious argument and exposition was condemned by his severe standards: but it is probably in this respect that current psychiatry, with all its achievements, has least to boast about. Thus a prominent colleague recently said, "In using terms like psychopathic personality, I always think that Krafft-Ebing's description of it as 'an insanity of altruistic feeling and a coldness of the heart' is extraordinarily good because that is precisely what the defect is": this sentence, easily paralleled in contemporary psychiatric writings, exhibits a style of thought and language such as often provoked Maudsley's scathing comments.

Maudsley's writings are little read today, and it would therefore be misleading to point, as one can, to many passages in his writings that correspond to recent advances, and so to claim prescience and parentage for him. But his indirect influence is discernible, sometimes where it would least be expected. It has lately been pointed out with justice by Philip Merlan that Freud must have been considerably influenced in his conception of the unconscious by Brentano, but Brentano's discussion of the problem, when one comes to study it in his *Psychologie vom empirischen Standpunkt*, 1874, is largely a closely argued examination of what Maudsley had written about it. Other examples of Maudsley's influence could be cited. Desmond Curran's recent address on "Psychiatry Limited" was in the straight line of descent from him; so, undoubtedly, were the writings of Edward Mapother, a potent teacher and leader of English psychiatry. The Scottish psychiatrists, whose contribution to the growth of the subject in Great Britain is so great, have been less obviously inheritors of Maudsley's spirit, though descent in the collateral line may be traced. Clouston, for example, the dominant figure in Scotland at the beginning of the century (and the teacher of Mac-Fie Campbell), was closely associated with Maudsley over many years and though they did not see eye to eye, was much influenced by the older man. However, you will hardly be interested in these questions of intellectual pedigree.

The picture of contemporary psychiatry in this country cannot be drawn within the compass of a letter; at all events the miniaturist would need a finer pen and better colours than I have. This scanty outline however may serve if, as I suppose, the chief differences between your psychiatric scene and ours are differences only of quantity and tempo.

DYNAMICS AND CLASSIFICATION OF DISORDERED BEHAVIOR [1]

SANDOR RADO, M.D., D.P.Sc.,[2] NEW YORK CITY, N. Y.

ORGANISMIC UTILITY: THE ADAPTATIONAL FRAMEWORK OF MEANING

I deeply appreciate the opportunity to address this general session. First may I define my concepts. Adaptations are improvements in the organism's pattern of interaction with its environment that increase the organism's chances for survival, cultural self-realization, and perpetuation of its type. "Autoplastic" adaptations result from changes undergone by the organism itself; "alloplastic" adaptations, from changes wrought by the organism on its environment. Phylogenetic adaptations are based on genetic mechanisms, such as *favorable* mutation—the appearance of potentially valuable new equipment. The phylogenetic accumulation of *unfavorable* mutations may lead to adaptive degradation, if not extinction of the organism and the species. In ontogenetic and situational (here and now) adaptations the psychodynamic master mechanisms are learning, creative imagination, and goal-directed activity.

Adaptational psychodynamics studies the part played in behavior by motivation and control. It deals with pleasure and pain, emotion and thought, desire and executive action, and interprets them in terms of organismic utility, that is, in an adaptational framework of meaning. Its foremost objective is to discover the mechanisms by which the psychodynamic cerebral system accomplishes its integrative task.

Adaptational psychodynamics is a development of classical psychodynamics, the theoretical system originated by Sigmund Freud, and is based on the psychoanalytic method of investigation. Looking forward to the achievement of a comprehensive, unified science of human behavior, adaptational psychodynamics places the analysis of behavior in the genetic, physiologic (biochemical, biophysical), and cultural contexts of the organism. It seeks to replace undefined and undefinable concepts by defined ones and to evolve a close-to-the-fact scientific language that will convey the most information in the fewest words. Even though the introduction of numerous new terms makes communication difficult at first, this is a crucial step toward an increasingly rigorous application of the scientific method.

Behavior disorders are disturbances of psychodynamic integration that significantly affect the organism's adaptive life performance, its attainment of utility and pleasure. They are thus marked by either (1) adaptive impairment, (2) adaptive incompetence, or (3) transgressive conduct. The term impairment indicates psychoneurosis; the term incompetence, psychosis; and the term transgressive conduct, psychopathic state.

In the analysis of behavior disorders we encounter organized sequences of events which we have come to recognize as processes of miscarried prevention and miscarried repair. They are brought into play by a disordered response of the organism which we can relate to an environmental situation and trace to comparable exposures in the past. Our analysis may thus penetrate to the point where, instead of an adaptive response, a disordered one made its first appearance. This difference cannot be explained by further psychodynamic analysis, which reaches here its terminal point. Nonetheless, we can continue the etiological inquiry. We can seek to disclose the cerebral mechanism of such a disordered psychodynamic response; we can study its broader physiologic context; and we can search for its genetic context.

The ideal etiological classification of behavior disorders will draw on their genetics and physiology as well as on their adaptational psychodynamics. Today our knowledge of the genetic and physiologic phases of etiology is too scanty to attain this goal. The best we can do is experiment with provisional classifications based mainly on the

[1] The Academic Lecture read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953. The 3 articles immediately following are discussions of Dr. Rado's paper.

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psychodynamic phase of etiology. This is what I have attempted to do in the following scheme.

Scheme of Classification

Class I. *Overreactive Disorders.*—(1) Emergency Dyscontrol: The emotional outflow, the riddance through dreams, the phobic, the inhibitory, the repressive, and the hypochondriac patterns. (2) Descending Dyscontrol. (3) Sexual Disorders: Disorders of the standard pattern. Dependence on reparative patterns: the patterns of pain-dependence; the male-female pattern modified by replacements; the eidolic and reductive patterns. Fire-setting and shoplifting as sexual equivalents. (4) Social Overdependence. (5) Common Maladaptation: A combination of sexual disorder with social overdependence. (6) The Expressive Pattern: Expressive elaboration of common maladaptation: ostentatious self-presentation; dream-like interludes; rudimentary pantomimes; disease-copies and the expressive complication of incidental disease. (7) The Obsessive Pattern: Obsessive elaboration of common maladaptation: broodings, rituals and overt temptations. Tic and stammering as obsessive equivalents; bedwetting, nail-biting, grinding of teeth in sleep, as precursors of the obsessive pattern. (8) The Paranoid Pattern.—Paranoid elaboration of common maladaptation: the nondisintegrative version of the Magnan sequence.

Class II. *Moodcyclic Disorders.*—Cycles of depression; cycles of reparative elation: the pattern of alternate cycles; cycles of minor elation; cycles of depression masked by elation; cycles of preventive elation.

Class III. *Schizotypal Disorders.*—(1) Compensated Schizo-adaptation. (2) Decompensated Schizo-adaptation. (3) Schizotypal Disintegration marked by Adaptive Incompetence.

Class IV. *Extractive Disorders.*—The ingratiating ("smile and suck") and extortive ("hit and grab") patterns of transgressive conduct.

Class V. *Lesional Disorders.*

Class VI: *Narcotic Disorders.*—Patterns of Drug-dependence.

Class VII. *Disorders of War Adaptation.*

Examples of Adaptational Dynamics of Behavior Disorders

This classification is a by-product of studies in the adaptational psychodynamics of behavior disorders, developing from the fact that the organism's first survival concern is safety. Walter B. Cannon has shown how, by their emergency function, the peripheral systems serve the whole organism's interest in safety. Following this clue, I have attempted to outline the emergency function of the psychodynamic cerebral system, terming it "emergency control."

However, if an *overproduction* of the emergency emotions such as fear, rage, and guilty fear is the organism's response to danger, it will be unable to handle effectively the exigencies of daily life. These disordered—excessive or inappropriate—emergency responses impede rather than aid the organism in its adaptive task. They elicit processes of miscarried prevention and miscarried repair that produce further disordering effects. These failures of emergency control lead to the simplest forms of behavior disorder, which I term "emergency dyscontrol."

With emergency dyscontrol as a point of departure, it was possible to arrange the clinically observed forms of behavior disorder according to the increasing complexity of their psychodynamic mechanisms. The resulting scheme somewhat resembles the known patterns in organic chemistry, where, starting with a simple compound, we may derive increasingly complex ones through rearrangement of the components or the addition of new components.

The various psychodynamic mechanisms of behavior disorders belong to different physiologic and genetic contexts. With advancing knowledge of these contexts the apparent inconsistencies of classification may be expected to disappear. For example, in time we should be able to characterize every behavior disorder by "lesions" of the underlying physiologic (biochemical, biophysical) functions; the separate class of Lesional Dis-

orders will then have outlived its usefulness. Our present difficulties with classification derive from lack of etiological knowledge, not from lack of logic.

To illustrate the material listed in the above classification scheme, I shall begin with the simplest psychiatric problem, the dynamics of emergency dyscontrol and descending dyscontrol (subclasses 1 and 2 of Class I. Overreactive Disorders), and follow with perhaps the most complex psychiatric problem, the dynamics of the schizotypal disorders (Class III). The pivotal task is the same in the dynamic study of all behavior disorders: to reduce a mass of observational data to an outline of their hierarchical organization.

CLASS I. OVERREACTIVE DISORDERS

The basic emergency emotions are pain, fear, rage, and, in a wider sense, guilty fear enhanced by retroflexed rage, and guilty rage. These emotions prompt the organism to emergency moves: pain elicits riddance, *i.e.*, activities aimed at getting rid of its cause; fear prompts moves of escape or submission to authority; rage evokes combat or defiance; guilty fear produces expiatory behavior aimed at recapturing loving care; guilty rage leads to violence in presumed self-defense. Retroflexed rage is defeated rage turned by the organism against itself; its self-reproach is usually assimilated with the prevailing pattern of remorse. By preparing the organism to meet emergencies, these emotions play a significant part in biologically effective emergency control.

Overproduction of these emergency emotions results in disordered—excessive or inappropriate—emergency responses which, instead of aiding the organism, threaten to damage it. The infantile organism is unable to control these disordered responses by its own psychodynamic means and enters upon a state of emergency dyscontrol. Proneness to overreaction and dyscontrol develops in childhood, presumably on a genetic basis, and is carried over into adult life.

1. *Emergency Dyscontrol.*—Failure of the organism to control its overreaction by its own resources results in the following patterns of emergency dyscontrol: the emotional outflow, the riddance-through-dreams, the phobic, the inhibitory, the repressive, and the hypochondriac.

In the *emotional outflow* pattern the organism seeks to rid itself of its excessive emergency emotions by fits of fear or outbursts of rage.

In the *riddance-through-dreams* pattern the same result is accomplished by means of enraged dreams or terror dreams.

Phobic behavior or phobic avoidance is a pattern of miscarried prevention. It usually originates in childhood, in the child's dependency relationship to his parents. The child is terrified by a chance experience, which would not produce such an overreaction in other children. To forestall the recurrence of this crucial attack of terror, he will henceforth automatically avoid the situation—the visual context—in which the terror occurred. Sometimes the child's overreaction is the consequence of a previous parental warning and threat of punishment. Magical thinking may make this mode of prevention retroactive; the child then forgets that the parental threat and his terrifying experience ever occurred. Once the avoidance mechanism is established, the child may, by generalization, use it for the magical control of other parental threats as well. If the object of the child's phobic avoidance is a "dangerous" animal, he may have a further gain: he may actually vent his repressed rage—his resentment of the threatening parent—on this "scapegoat." Phobic avoidance in the adult retains these infantile features.

The *inhibitory* is also an infantile pattern of miscarried prevention, but with 2 different mechanisms. The first prevents the recurrence of a crucial attack of fear by the organism's automatically inhibiting the motor activity—the proprioceptive context—in which the attack occurred. The other shows an even higher degree of foresight misapplied: to play safe, the organism automatically inhibits not only the activities tabooed by the authorities, but on an ever-widening scale, also the *approaches* to those activities.

In the *repressive* pattern, while unable to stop the overproduction of emergency emotions, the organism succeeds in automatically cutting off these emotions from consciousness and outward discharge. This mechanism is of course powerless to halt an eventual

overflow of the repressed emotions, which are thus bound to produce further disordering consequences.

Since fear and rage are antagonistic responses, open fear is often accompanied by repressed rage; I call this dynamic formation fear over rage. Similarly, open rage may be accompanied by repressed fear; this is called rage over fear. The battle between fear and rage is strongly influenced by the conflict between the organism's desire for security through dependence and its pride in cultural self-realization. Fear over rage shows victory of the dependency need; the resulting combination of repressed rage and hurt pride is a prolific though less conspicuous source of the patient's suffering. The contrary outcome—rage over fear—shows victory of the organism's pride in having its own way. Incomplete repression of fear and rage may produce qualitatively undifferentiated chronic tension states, marked by apprehensiveness or irascibility or both.

The *hypochondriac* pattern is marked by an excessive outflow of unrecognized guilty fear. Frantically, the patient dreads illness: in his nonreporting (unconscious) belief illness is a long overdue punishment for past disobediences (sexual self-stimulation, truculence) now catching up with him. Often the attack climaxes in an act of riddance (unnecessary surgery, precipitation of actual illness, etc.). This pattern defeats its preventive and reparative intents completely: it increases rather than decreases the overproduction of hypochondriac (that is, guilty) fear. Beneath hypochondriac (guilty) fear there is always repressed rage and hurt pride.

Following the pattern of its desires, the healthy organism seizes opportunities to attain utility and pleasure. Emergency dyscontrol interferes with these pursuits; it reduces the adaptive value of the patient's life performance and tends to make him dependent on external help. If his life situation —his relatives and friends—permits, he capitalizes on his illness; he vents his repressed rage and recaptures his pride by exploiting the privileges of the sick in the manner of a child. The same infantile and vindictive exploitation of relatives and friends may occur in every form of disordered behavior, or for that matter, in every illness. *Emergency dyscontrol enters as a basic etiological factor into the emotional dynamics of almost all behavior disorders.*

2. *Descending Dyscontrol.*—The autonomic overdischarge of excessive or inappropriate emergency emotions may precipitate disease processes in the peripheral systems affected. The psychodynamic cerebral system becomes aware of the peripheral disease thus precipitated, and responds to this internal event just as it responds to events in the environment. Descending dyscontrol thus brings into play a circular operation of responses, which I call the *psychodynamic circuit of peripheral disease.* The same circuit eventuates if a peripheral disease of purely peripheral origin elicits emergency overreaction with autonomic over-discharge. Clearly, psychodynamic circuit and purely peripheral physiology are interdependent and inseparable components of the same organismic context. By including the concept of psychodynamic circuit in its body of theory, purely physiological medicine advances to comprehensive medicine.

CLASS III. SCHIZOTYPAL DISORDERS

The conceptual scheme of schizotypal organization evolved from the concept of schizophrenia; we shall first briefly review this development.

In 1911, E. Bleuler defined schizophrenia as follows: "This disease is characterized by a specific type of alteration of thinking, feeling, and relation to the external world, which appears nowhere else in this particular fashion."

The current genetic theory of schizophrenia traces its etiology to an inherited predisposition, transmitted to an offspring from both parents by a Mendelian mechanism.

In Dobzhansky's formulation genotype is the inherited cause of development, and phenotype—the organism as it appears to our senses in structure and function—the actual outcome of development. In this sense the patient suffering from an open schizophrenic psychosis is a schizophrenic phenotype, engendered by a schizophrenic genotype in its interaction with the environment. A phenotype changes continuously throughout the

life span; its development is circumscribed by the genotype's "norm of reaction" to changing environmental influences.

For psychodynamic purposes I shall abbreviate the term schizophrenic phenotype to *schizotype*. Can we diagnose the patient's inherited predisposition before he develops an open psychosis or even if he never develops an open psychosis? In other words, are we prepared to view him as a schizotype from birth to death, or only during his open psychosis? Clinical observation gives us the answer.

The manifold clinical pictures—symptoms and syndromes—of the schizophrenic psychosis have been described and classified by many clinical investigators; there is substantial agreement on almost all cardinal points. But when we subject these gross manifestations of the open psychosis to minute psychodynamic analysis, we discover an underlying ensemble of psychodynamic traits which, as we shall presently see, is demonstrable in the patient during his whole life. This finding will define him as a schizotype from birth to death, and will allow us to view his life history as a sequence of schizotypal changes. The ensemble of psychodynamic traits peculiar to the schizotypes may be called *schizotypal organization*. It is this organization which is meant by the prefix *schizo-* because this organization constitutes the psychodynamic expression of the schizophrenic genotypes. Conversely, we may define a genotype as schizophrenic if its norm of reaction is schizogenic.

Before outlining this concept of schizotypal organization I shall review some relevant propositions of adaptational psychodynamics. On evolutionary as well as clinical grounds I have suggested elsewhere that in the psychodynamic cerebral system integrative activity is spread over a hierarchy of 4 levels. In ascending order, we speak of the hedonic level, the levels of brute emotion, emotional thought, and unemotional thought.

At the hedonic level the pattern for hedonic self-regulation is established: the organism moves towards the source of pleasure and away from the cause of pain. It relies on the expectation that pleasure signals the presence of needed supplies or conditions otherwise favorable to its survival, and pain the presence of a threat to its organic integrity.

At the next 2 levels the emotions are the controlling means of integration. Emotions are central mechanisms both for the arousal of the peripheral organism, and for the peripheral disposal of superabundant central excitation. We divide them into the emergency emotions based on present pain or the expectation of pain, such as fear, rage, retroflexed rage, guilty fear, and guilty rage; and the welfare emotions based on present pleasure or the expectation of pleasure, such as pleasurable desire, joy, love, and pride.

Unemotional thought forges the tools of common sense and science. By teaching the organism to support present pain for the sake of future pleasure, foresight increases the flexibility of hedonic self-regulation.

Behavior of the whole organism may be integrated at any of these 4 levels or at any combination of them. Integrative activity may be in part nonreporting (unconscious), in part self-reporting (conscious); accordingly, the psychodynamic cerebral system falls into the nonreporting and self-reporting ranges. To advance from the nonreporting to the self-reporting range, cerebral activity must pass the pain-barrier, an organization of precautionary mechanisms upon which hedonic control rests. Communications of the organism to the environment must pass the social pain-guard, an analogous organization of precautionary mechanisms, superimposed on the pain-barrier.

The conscious range is dominated by the supreme integrative system of the entire organism, which I call its *action-self*. Of proprioceptive origin, the action-self emerges from the circular response pattern of self-awareness and willed action. It then integrates the contrasting pictures of total organism and total environment that provide the basis for the selfhood of the conscious organism. These integrations are fundamental to the organism's entire orientation and represent highly complex organizations composed of sensory, intellectual, emotional, and motor components. At first the organism attributes unlimited power to its willed actions; hence its first thought-picture of itself is one of an omnipotent being. This early thought-picture—designated as its pri-

mordial self—remains the source of its indestructible belief in magic. Recognizing the difference between attainment and aspiration, present and future, the maturing organism differentiates its thought-picture of self into a tested self and a desired self. However, under the pressure of strong desire, this forced and precarious differentiation tends to disappear.

Using this framework of meaning, I can state in simple terms the basic observation upon which the conceptual scheme of schizotypal organization rests. *In the schizotypes the machinery of psychodynamic integration is strikingly inadequate, because one of its essential components, the organizing action of pleasure—its motivational strength—is innately defective. My term for this crucial defect is "integrative pleasure deficiency."*

This formulation derives from 2 sets of data. First, the patient himself often realizes that his pleasure, his pleasurable emotions and thoughts, are inadequate if not rudimentary. "I am," said one of our clinic patients, "incapable of giving and sharing love"; and again, "I do not know how to react with people." Secondly, we can conveniently observe the motivational strength, the integrative action and scope, of the patient's emotions. We then see that the integrative action of his welfare emotions as well as of his pleasure is significantly diminished. We shall now explore the far-reaching consequences of this condition.

It is generally known that pleasurable emotions facilitate performance, keeping our zest to live at a high level. Insufficient pleasure hinders performance; the schizotype's zest for life is reduced. The welfare emotions also counterbalance the pain-connected emergency emotions. In the schizotypes, motivational weakness of the welfare emotions causes an emotional disbalance; without this adequate tempering influence the emergency emotions tend to grow excessive in motivational strength and integrative scope. The extraordinary strength of fear in the schizotypes so impressed some observers that they called it *existentialangst* (fear of existence); the same excessive strength marks schizotypal rage, once it has free rein.

Integrative pleasure deficiency impairs the ontogenetic development of the action-self. Pleasure is the tie that really binds. An action-self deficient in connective pleasure is brittle, prone to break under stress, to lose control of the contrasting integrations, total organism, and total environment. This weakness of the action-self is the basis of the patient's oversensitivity and profound insecurity in relation to himself, to his bodily parts, and to his environment. His insecurity in human relationships is aggravated by further consequences of the patient's pleasure deficiency. Because his capacity for affection and human sympathy is reduced he cannot reciprocate when receiving them, still less elicit them. Small wonder he finds it difficult to get a firm emotional foothold in family or other groups.

The patient's limited capacity for pleasure and love renders the ontogenetic development of a healthy sexual function impossible. The resulting sexual organization is rudimentary, ill-proportioned, lacking in genuine love and tenderness, subject to fragmentation and formation of miscarried reparative patterns.

The integrative pleasure deficiency is indeed fundamental and all-pervasive: it leaves no phase of life, no area of behavior unaffected. As anticipated in Bleuler's first definition, the schizotypes differ fundamentally from other human types. Often enough the patient knows this himself: he longs to be like other people. To stress the radical importance of schizotypal organization, we must describe the life performance of the patient so organized in terms not of adaptation, but of a schizotypal system of adaptation, or, briefly, schizo-adaptation.

The degree of the innate integrative pleasure deficiency and the consequent task of schizo-adaptation vary widely from patient to patient. The outcome of the patient's struggle for human existence depends upon the relation of his adaptive resources to the adaptive burden of his changing life situation. To take care of its deficiencies, the organism must evolve (1) a scarcity economy of pleasure, (2) a security pattern featuring compensatory dependence, and (3) a replacement technique of integration in which the job ordinarily done by pleasurable feeling and thought is shifted to unemotional thought. It is, I suggest, the combination of

these 3 reparative processes upon which the entire system of schizotypal adaptation rests.

Though we have not yet succeeded in reducing the scarcity economy of pleasure to its elementary mechanisms, its beneficial results are readily observable. Its efficacy appears to depend on the available degree of intelligence, foresight, capacity for learning, and the absence—successful avoidance or control—of emergency overreactions detrimental to pleasure. While an endowment for superior performance facilitates the task of husbanding pleasure it may introduce new complications. The schizotypes show the same variety in endowment as the rest of the population; some of them have superior intelligence, special artistic, scientific, or other gifts. The favored pursuit of a patient belonging to this elite group tends to absorb whatever capacity he has for pleasure, leaving him disastrously vulnerable to failure, actual or presumed.

The need for compensatory dependence accompanies the schizotypes throughout the life span. Often without realizing it, the patient leans heavily on external support, his relationship to others remaining that of the child to his parent. Perpetuation of this infantile need is further complicated by the fact that in a schizotype, the child's security pattern of dependence is defective from the outset. As a child a schizotype is terrified by conflict and resents the necessity of engaging in sibling rivalry or having to play one parent against the other; he would prefer to lean on everyone within his reach. He cannot give affection, the means of ingratiation; hence his response to parental demands is chiefly limited to fear or rage, obedience or defiance, yes or no; the all-important range of "between" is undeveloped or atrophied by disuse. Under stress the adult patient tends to revert to his infantile belief that an ersatzparent can and will supply his needs by magic.

The replacement technique shifts the integrative task from pleasurable to cold thought. Schizotypes lack the feel for the simple pleasures, the affectionate give-and-take of daily life. In lieu of immediate emotional grasp the baffled patient presses his intellect into service, as if trying to pick up something at a distance with lazy tongs. For the spontaneous pleasurable responses he lacks he substitutes mechanical limitations. If highly sophisticated, he may ridicule the conventional forms of affectionate behavior, dissecting and examining them as though they were the technological performance of a machine.

In favorable circumstances this system of adaptation may hold the schizotype in a compensated state. He may, in fact, go through life without ever suffering a breakdown. However, his sensitivity to loss of affection and pleasure is extreme. Because he knows only rudimentary pleasure, such warmth as he is capable of deriving from being loved has for him a unique facilitating and reassuring value. Any change in his life situation that deprives him of this help, thus undermining his pleasure, security and self-confidence, becomes a threat of decompensation. Every shred of activity he enjoys plays an important part in his equilibrium; every loss of pleasure is a tragedy which he blames on his parent or ersatzparent. He may feel harassed from without, though the fact is that it is he who drives himself too hard. Under growing pressure he develops excessive fears, guilty fears, and rages, blurred awareness and magic thought. These inordinate emergency responses signify the onset of decompensation. In a self-defeating effort to cope with these responses, to recapture his pleasure and security from dependence, he develops a scrambled form of emergency dyscontrol which is peculiar to the decompensated schizotypes. Ordinary dyscontrol seen in other types eventuates in phobic, hypochondriac, expressive, obsessive, paranoid, and other overreactive patterns which are circumscribed and intricately organized. In the decompensated schizotypes these mechanisms appear in a scramble and are much more simply organized, springing directly from the patient's obedience-defiance conflict.[3] He may feel profoundly humiliated

[3] In 1914, exploring the value of the libido theory for the interpretation of schizophrenia, Freud contrasted the neurotic (overreactive) pictures developed by schizophrenics with those developed by patients other than schizophrenic: "The difference between the transference neuroses arising in this way and the corresponding formations where the ego is normal [*i.e.*, non-schizophrenic] would afford us the deepest insight into the structure of our mental apparatus."

or disgusted with himself, experiencing diffuse and strange bodily sensations or even fearing that his body undergoes a revolting decomposition. He may sense the threat of disintegration and fear that he is losing his mind. He struggles desperately to retain adaptive control; this struggle is pathognomonic of the decompensated schizotypes. When he is overcome by the impatience of a hungry infant and in addition his remorse defeats his resentment, he may develop a facade of depression or find "relief" in alcohol-dependence. Decompensation often includes endocrine or other peripheral disturbances; in the female patient a conspicuous symptom is arrest of the menses.

As distinguished from the various forms of adaptive impairment, schizotypal decompensation is a state of threatening adaptive incompetence. The decompensated patient is left with but one remedial resource, his integrative machinery of unemotional thought. This machinery may hold firm or it may slowly or rapidly break down. Should it collapse, the patient enters upon a process of schizotypal disintegration marked by adaptive incompetence.

The first sign of disintegration which the patient cannot hide from the environment is his thought disorder. Apparently this disorder is a direct consequence of the overburdening of the cognitive function. However, closer scrutiny reveals the presence of a less conspicuous but all the more important factor that complicates this untoward development. In actual fact the process of disintegration begins not with a thought disorder, but with an extensive *proprioceptive disorder,* a distorted awareness of bodily self. Usually its first manifestations have already appeared at the stage of decompensation.

This proprioceptive disorder eludes psychodynamic explanation. We understand neither its cause and course of development, nor its relation to the integrative pleasure deficiency. But we can see that it disorganizes the action-self with fateful consequences. The organism now ceases to have a definite selfhood, for the disorganized action-self cannot sustain the 2 basic integrations—total organism and total environment—upon which selfhood depends. Psychodynamic life is now the interaction of a *fragmented* organism with a *fragmented* environment.[4] The patient loses his grasp and control of himself as well as of the environment. I suggest that proprioceptive awareness is the deepest internal root of language and thought. By increasing the integrative burden of the already overtaxed cognitive function, proprioceptive disorder precipitates its breakdown. The patient glides into a many-faceted thought disorder that can be understood only by a comparison with normal thinking.

The healthy organism, moving from desire towards fulfillment, analyzes experience into cause and effect so that it can find the means that will lead to the ends it desires. Normal thinking is like a suspension bridge between organism and environment. Schizotypal thinking, if severely disordered, buckles this bridge and lifts it into the air; in Bleuler's terms, it is then both de-reistic and de-personalized.

Stressing the adaptive function of thinking, physicist Ernst Mach pointed out that thought organization proceeds in 2 consecutive steps: we adjust our thoughts first to the facts and then to one another, achieving a dependable degree of objectivity, logical consistency, and thought-economy. However, Mach's formulation applies only to unemotional (objective, rational, realistic) thought. In emotional thinking the adjustment of thoughts to facts is inadequate and the adjustment of thoughts to one another aims not at logical but at *emotional* consistency. Furthermore, since thought processes take place in both the nonreporting (unconscious) and the self-reporting (conscious) ranges of the psychodynamic cerebral system, simultaneous processes of emotional thought in the nonreporting range, though consistent in themselves, may be at variance with one another as well as with the facts. The characteristics of nonreporting thought-organization (Freud's "primary process") are revealed through the analysis of dreams; emotional thoughts marked by the characteristic features of primary organization and a total lack of adjustment to the world of facts may be called prime thoughts.

[4] The term "fragmentation" was first used by William A. White; he meant by it a "molecular splitting of the psyche."

The raw material of conscious thinking comes in part from the sense organs, in part from the nonreporting range. On their way, as stated above, prime thoughts must pass the pain-barrier; intended communications to the environment, the social pain-guard. We also stated that pain-barrier and social pain-guard are precautionary mechanisms of hedonic control; let us now add that conscious thought-adjustment is the rational mechanism of adaptive control of both the environment and the organism itself.

These 3 mechanisms are wrecked by the disintegrative process. Prime thoughts may then enter freely the self-reporting range, escape conscious adjustment and be blurted out or acted out. There appear hallucinations and delusions which preclude the adjustment of thought to fact even if the requisite machinery is still available. Hallucinations are prime thoughts perceived as data of the senses; therefore they have the factual reality of perceptions. Delusions are prime thoughts exalted to the plane of fact-adjusted thought by the magic of the strong emotions from which they spring and by which they are controlled; for this reason they are impervious to refutation by the true facts.

Often the earliest sign of incipient thought disorder is the loss in hierarchical depth: thought organization tends to be replaced by thought aggregation, vertical meaning by horizontal irrelevance, sense by sound. As rationality dwindles to the vanishing point, infantile tonality emerges as an ordering principle.

Disintegration of the machinery of adaptive thinking renders the patient incapable of sustaining effective human relationships. He has no facilities to handle a many-sided group situation; in his fragmented field there is room for but one protagonist at a time. He seeks to operate on a child-parent dependency pattern stripped to the bone. His choice of response is now rigidly limited to yes or no (obedience or defiance); the range of "between" disappears completely. Moreover, he tends to perceive both alternatives as equally undesirable: he faces not a choice but a dilemma of yes or no. This applies to the entire gamut of his responses, intellectual, emotional, and motor.

At the same time, almost identical changes take place in the patient's relationship to himself, in his mode of handling his own impulses. To understand these changes, we shall again take a comparative view of the healthy organism.

During the period of growth the psychodynamic cerebral system builds a semiautomatic organization of self-restraining and self-prodding responses known as our conscience. The child learns to anticipate certain parental and other authoritarian demands to which he is continuously exposed, and to meet them automatically.

The same applies to the system of enforcement used by the parents. Parental reward gives rise to automatized self-reward known as self-respect and moral pride; parental punishment, to automatized self-punishment as a means of expiating one's presumed wrongdoings and reinstating oneself in the loving care of the authority thus reconciled. The adaptive gain of conscience is security through obedience; its main problem is the handling of defiant rage.

In the disintegrating schizotype, impairment of the action-self breaks up the context in which the mechanisms of conscience operate. Subsequently, it is no longer his conscience that admonishes him but once again the disciplinary authority of his present or past. Freud discovered this regressive replacement of conscience by the original child-parent relationship in paranoid behavior. Today we realize that this regression, a disintegration of the "voice of conscience," takes place in all disintegrating schizotypes; the paranoid is its most conspicuous manifestation. Continuing the reparative intent of the voice of conscience, this regression seeks to reinforce the faltering mechanisms of conscience by reactivating the infantile experiences from which they originate. To the extent to which the true mechanisms of conscience fail to operate, the patient loses his ethos—his system of shared emotional values upon which cultural group membership rests. As we have seen, the disintegrating patient's human relationships are reduced to the scant residues of his infantile dependency pattern; this same pattern replaces his conscience, his human sympathy, integrity, and standards as well. As a consequence,

when the patient has to act upon his own impulses, he faces the same yes-or-no dilemma as he does in his vestigial relationships to others.

The yes-or-no dilemma ushers in the yes-or-no disturbance which is peculiar to schizotypal disintegration and forms the core of what is known as the patient's activity disorder. In a challenging situation, be the stimulation external, internal, or both, the patient may be completely blocked by his dilemma and respond only with paralyzed perplexity. Or he may try to obey and defy simultaneously, presenting a picture of intellectual, emotional, or motor confusion. Or if he gets going in one direction he may be unable to stop, continuing or repeating the same response regardless of the changing situation. Whether the resulting behavior shows automatic obedience or automatic defiance, it is unrelated to the adaptive task and is as a rule terminated by a sudden and unpredictable shift.

The symptoms resulting from the yes-or-no disturbance are well known to the clinician. They include perseveration, echolalia, echopraxy, negativism, overtalkativeness, mutism, akinesia, hyperkinesia, inappropriate emotional or motor response, stereotypes, gesturing, posturing, grimacing, extreme muscular and postural flexibility or rigidity, and finally, schizotypal excitement and stupor.

The yes-or-no disturbance, though dominated by the obedience-defiance conflict of the infantile dependency pattern, has still deeper roots in the functional design of the sensory-motor organism, notably in the contrast and persistence principle of perception and in the principle of reciprocal innervation of muscles.

The disintegrating patient may retreat into a magic universe of his own creation. Unlike the magic world of ordinary day-dreaming, the magic universe of the disintegrating schizotype is split off into irreconcilable fragments. Creative imagination disintegrates as soon as the organism loses the unity and coherence of its thought-picture of self. This is reflected in the patient's regression to archaic sources of pleasure, in his excitements, hallucinations, delusions, posturings, and other activities detached from the actual environment. Fragmentation of his magic universe may be directly represented in his dreams and artistic creations which with telling frequency feature dismemberment, isolated or dead bodily parts, and related motifs.

The patient's subjective experience, his awareness of his own disintegrating activity, eludes our comprehension. He may show signs of what Jaspers calls "double orientation": while interpreting his perceptions (thoughts, hallucinations, actions) in a disrupted context of irrationality, he simultaneously records them in the context of residual enfeebled rationality. This shadowy perpetuation of the true environmental context may enable the delusional patient suddenly to recapture realistic contact without relinquishing his delusions or, if the thought disorder subsides, to see his delusions in retrospect against the world of facts.

The remarkable phenomena of double orientation show that the disintegrating patient still struggles to maintain adaptive control. However, the disintegration of function prepares the ground for a cessation of function. This malignant turn occurs if the organism, tiring of the struggle, gives up and withdraws. There follows a process of deterioration, a progressive functional shrinkage of the psychodynamic cerebral system. The process may lead to a total retreat from the adaptive task: the patient becomes a living corpse. His withdrawal from the struggle for existence is the ultimate consequence of the disease process, not its cause.

I have shown that the characteristics of the schizotypes stem from an integrative pleasure deficiency. This defect is a basic and, in my view, innate trait of schizotypal organization. However, proprioceptive disorder, with its highly disintegrative effect, cannot be traced to this pleasure deficiency. Thus one must assume that *a predisposition to proprioceptive disorder, a sort of proprioceptive diathesis, is another basic trait of schizotypal organization.* The significance of proprioceptive disorder underscores the necessity of correlating the psychodynamic mechanisms just described with the broader context of the still unknown physiologic mechanisms in which they operate. Only through such cross-interpretation can we hope to arrive at a comprehensive theory of schizotypal organization.

On psychodynamic grounds I view schizotypal disorders as developmental stages of schizotypal organization:

III. 1. *Compensated schizo-adaptation.*—This is a relatively stable stage, marked by adequate operation of the schizotypal system of adaptation. Though there is a liability to decompensation, the patient may remain at this stage throughout life. The so-called schizoid is viewed here as a well-compensated schizotype.

III. 2. *Decompensated schizo-adaptation.*—This stage is precipitated by emergency dyscontrol and its consequences, which overtax the security pattern of compensatory dependence and destroy the scarcity economy of pleasure. The patient develops a scramble of overreactive mechanisms (as distinguished from organized overreactive patterns seen in other types) and the first signs of proprioceptive disorder. Though he may remain at this stage for an indefinite time or recover spontaneously, he is now threatened by disintegrative breakdown. This is the stage labeled recently by P. Hoch and P. Polatin "pseudo-neurotic schizophrenia."

III. 3. *Schizotypal disintegration marked by adaptive incompetence.*— This is the stage known as open schizophrenic psychosis. The focus of the disintegrative process is disorganization of the action-self which, brought about by a psychodynamically unexplainable proprioceptive disorder, in turn precipitates disorders of thought, activity, etc. There is a chance of spontaneous remission, and, on the other hand, a liability to progressive deterioration.

This developmental outline suggests how pressing is the need to find the criteria for the stability of the compensated stage; and the criteria for determining the patient's liability to decompensation, disintegration, and deterioration as against his chances for spontaneous remission.

Concluding Remarks

The adaptational theory of disordered behavior, examples of which I have just presented, has evolved gradually over a period of years and rests upon clinical data. This is also true of the adaptational psychodynamics of healthy behavior, a subject to which I could make only scanty references in this paper.

My hope is that an adaptational dynamics of disordered behavior will stimulate physiologic and genetic studies, but the main task will be to test its fruitfulness in psychodynamic and therapeutic quests.

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I. DISCUSSION OF DR. SANDOR RADO'S ACADEMIC LECTURE[1]

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Thirty-five years ago at the annual convention of this Association, its president, that great American psychiatrist, Ernest Southard, proposed his celebrated reformulation of psychiatric nosology into 11 major groups. In speaking of this and of the plans for the years ahead he was never to see, he said:

> Perhaps it is in definition that I am most interested. Perhaps I believe that the world can get forward most by a clearer and clearer definition of fundamentals. Accordingly, I propose to stick to tasks of nomenclature and terminology, unpopular though they may be.

In this, as in so many other things, Southard was far ahead of his times. American psychiatry was still under the sway of the Kraepelinian system which Adolf Meyer had introduced. As a matter of fact, Meyer was as dissatisfied with the Kraepelinian nosology as was Southard, and he, too, proposed a classification of mental illness. Neither Southard's nor Meyer's classification was accepted or widely appreciated. Indeed, the whole subject of psychiatric nosology vanished from the programs and avowed interests of this organization for many years. Now and then a voice of experience, such as of Karl Bowman, Stanley Cobb, or George Stevenson, cried out in protest like the ancient prophets of Israel, but these cries went unheeded.

Faced by the innumerable problems resulting in the military experience from the discrepancies between our terms and our concepts, my brother William, then Brigadier-General in charge of psychiatry in the U. S. Army, felt obliged in 1943 to cut the Gordian knot of tradition-bound terms and obsolete concepts by formulating *de novo* a classification to correspond in some measure with our present-day practice and largely based on psychodynamic principles. In this he was loyally assisted by many members of this Association although the Committee on Nomenclature of that time took a position in opposition to change. The result of these efforts, compromised though they were in the course of obtaining concurrences from various military and civilian authorities, made for an enormous practical advance, and was soon adopted by the Army, Navy, and the Veterans Administration. The new Committee on Nomenclature of this Association, headed by Dr. George N. Raines, adopted with some few modifications this product of military necessity as an operating tool for civilian practice in the extraordinarily fine Manual which we are all using.

No one is more aware than my brother, those of us who worked with him, and Dr. Raines and his committee, that even this present classification is imperfect. Hence, no one is more gratified, I am sure, than they to see the revival of interest in the problem of nosology represented at this meeting. We have just heard an academic lecture, the subject of which was "The Dynamics and *Classification* of Disordered Behavior" [italics mine]. At the meeting of the American Psychoanalytic Association last week, a full-day's session was occupied with a discussion of the disease process in relation to a better ordering of nosologic concepts. Last night a spirited round-table discussion was devoted to diagnostic and nosologic problems. Thus, after 35 years, we get back to serious consideration of a topic which Ernest Southard and Adolf Meyer regarded as of pre-eminent importance in 1918.

It was Goethe who said that the history of a science is the science itself. To consider the problems and the issues surrounding the classification of mental illnesses, we would have to review the entire history of the attempts to bring order and system into the infinite variety of emotional states and behavior disorders that are lumped together under the broad heading of mental illness. We would have to begin with the earliest known report, recorded in hieroglyphics on papyrus about 3000 B. C., and continue through many blundering efforts to establish

[1] This article and the 2 immediately following are discussions of the preceding article, Dr. Sandor Rado's Academic Lecture, "Dynamics and Classification of Disordered Behavior," read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

an order that satisfied both the eager makers and the intended users, up to the sixth day of May, 1953. Only in the light of historical perspective is it possible to evaluate contemporary approaches to the problem of nosology.

Classification is one method, probably the simplest method, of discovering order in the world. By noting similarities between numerous distinct individuals, and thinking of these individuals as forming one class or kind, the many are in a sense reduced to one. To that extent simplicity and order are introduced into the bewildering multiplicity of nature. Our motives for attempting the establishment of this order may be scrutinized on the conscious or on the unconscious level. Strivings for the mastery of the anxiety created by disorganization, wistful glances at omnipotence, practical urges for more accurate communication and understanding may, in the one instance or the other, predominate. I have recently had occasion to review the various psychiatric nosologies—and it turns out that there are hundreds—that have been proposed since the simple triad of Hippocrates—dementia, melancholia, and mania. It becomes obvious in such a review that the mental process by which a classification is organized reflects the psychology of the organizer, and it becomes apparent that classification as a form of behavior cannot be regarded as existing apart from the classifier who undertakes it, and the audience to whom he proposes his product. Invariably the psychiatrists of history and the psychiatrists of today have met with the same dilemma, that of an inextricable relationship between the *method of classification* and the *basis upon which the classification is made*. There was a long period when symptoms alone formed the material which psychiatrists attempted to classify. At first, as with Celsus, Aretaeus, Avicenna, Prichard, and many others, these symptoms were classified descriptively. Under the influence of Emmanuel Kant, Plater, Pinel and some others who attempted *logical* classifications, nosologies were carried to a systematic (if somewhat preposterous) extreme by Linnaeus and by others who were influenced by him, such as Cullen and Ziehen.

Explanatory methods of classification engaged a much longer list of colleagues at a more advanced stage of psychiatric knowledge. For the first time the *course of the illness* rather than the symptoms themselves was made the basis of the classification, as by Kraepelin. This was an advance, but it too failed.

In more recent years, under the impetus of the discoveries of Sigmund Freud, we have *de facto* assumed a new basis for classification—one based on process. The curious fact is that, except for the previously mentioned efforts of my brother and of Dr. Raines, there has been no official endorsement of the psychoanalytic basis for classification in psychiatry. Psychoanalysis has developed on a somewhat esoteric and restricted basis. Its language and formulations became as characteristic and identifying as a foreign language, so that to the extent that its terms were adopted in general psychiatry, they were necessarily put in italics and quotation marks. Many of us have deplored this and tried to find ways to amalgamate them.

The curious thing is that the resistance to the more official incorporation of psychoanalytic concepts into psychiatric *nosology* and *terminology* has come not alone from nonanalytic psychiatrists but from the psychoanalysts themselves, who feel apprehensive lest the meaning of their special language become diluted and distorted by such an incorporation. Such fears are not ungrounded, for it is indeed dismaying to hear terms like "transference," "conversion," and "defense" used so carelessly, so inaccurately, and yet so widely. But this was inevitable and what is now appearing and what must be stimulating to us all, regardless of its concomitant discomforts, is the reorganization of psychoanalytic formulations in broader and less esoteric terms—a reorganization that inevitably includes psychiatric formulations as well.

This, as I understand it, is what Dr. Rado has been attempting. His brilliant contributions to psychoanalytic theory of ego function, addiction, and many other topics, established his reputation as a leading psychoanalytic thinker years ago. His efforts would give psychoanalysis a broader base of reference, establishing for it a more definite allegiance to, and inclusion in, psychiatric theory and practice. It should be welcomed by those of us who have taken this position

from the beginning and have hoped for this marriage of minds for a long time.

Now, whether or not this glimpse he has given us of his thinking is completely convincing as to its usefulness or fits in with our own amateurish efforts to do the same thing is somewhat beside the question. I would not be candid if I did not admit that Dr. Rado's scheme for accomplishing this is quite at variance with my own. But it is Dr. Rado's schema that we discuss here today, and I shall resist that human propensity of which John Whitehorn has written recently, viz: to find oneself almost imperceptibly, as it were, trying to make his own opinions prevail rather than really to find a common basis of conclusion and reason with others. "One of the greatest impediments to communication," says Whitehorn, "is the tendency to get spurred on to a kind of assertiveness, ascendancy or domination when faced with other people who offer possibilities of being dominated, coerced or otherwise beaten into agreement with you."

I have no illusions about the possibility of "dominating" Dr. Rado or "coercing" him into agreement with *me*. In what I believe to be the *spirit* of his effort, I am with him. I see in this no surrender of my commitment to the basic principles and theories of Sigmund Freud. I am considered, I believe, and indeed I so consider myself, to be on the far right wing of Freudian orthodoxy, but this does not prevent me from seeking to improve on the formulation, designations, and orientation of psychoanalytic concepts in the perspective of psychiatry in the broader sense. I believe in the unity of truth and in the unity of science, and I share an internal yearning for a unification of concepts relating to the same material, which otherwise becomes artificially ranged against one another as competitive and conflicting. But any practical, specific attempt to do this reawakens the fears on the one side of being absorbed and lost in a greater unity, and fears on the other side of being contaminated and perverted. The emotional reactions to any effort to reorganize the perspective of thinking or, more accurately, to reorganize the denominative symbols of thinking, arouse these sharp emotional reactions. There is an apprehensiveness in regard to change, a feeling that one is about to be swallowed up in a vast United Nations, or United Church, or United Science, or United Psychiatry, in which one will lose something of his individuality with some justice.

At the annual meeting of the American Psychoanalytic Association last week, a full day was designated for the discussion, by a panel in a section of the meeting, of the proposals which I, myself, have made along these same lines (nosology). It was interesting to observe how it aroused in the audience what we Freudians sometimes inaccurately call ambivalence, and what is better described as " conscious conflict." My proposals were described on the one hand in very flattering terms, and on the other hand as "radical," "useless," "negligible," and "dangerous"! They were treated as gingerly and cautiously as if I had presented the audience with a piece of ore that *might* contain *gold*, but might on the other hand contain dangerous radio-active isotopes. Dr. Rado, the very man whose paper I am now discussing, was finally impelled to push his way to the rostrum and declare that however valuable or valueless it might be considered, the effort to attempt it required great courage. I appreciated these words from Dr. Rado and I now return them to him, with interest!

Dr. Rado is a little *over*courageous, perhaps—yes, even a little provocative—in his techniques of presenting his ideas. He introduces some rather unnecessary confusions and irritations. His statements of opinion are often couched in a dogmatic, uncompromising manner. He takes disturbing liberties with the language. He discards without a word of reference some of the ideas and concepts familiar to all of us, and calls some of our old friends by new and strange names.

Now, it is certainly Dr. Rado's privilege to do this, but I submit that it adds to his difficulties or, perhaps I should say, to *our* difficulties. For it is our obligation, I believe, to try to surmount our emotional and intellectual resistances and attempt to comprehend the sense of what he is trying so earnestly to communicate. I concentrated my attention on the nosological suggestions included in the first 8 pages of the manuscript which he was so kind as to let me see, leaving the large and controversial subject,

the nature of schizophrenia, to my colleagues to comment upon.

Dr. Rado began by defining some terms. This is assuredly a worthy and proper scientific procedure. Unfortunately, however, the concepts and terms which Dr. Rado defined in the first paragraph are familiar ones, scarcely requiring definition, and strangely enough they are terms almost never again referred to in the paper. On the other hand, there appear throughout the essay numerous unfamiliar terms and strange neologisms which are introduced often without definition, or with such scanty definition as to beg the question as to their meaning or usefulness. I must confess complete ignorance, for example, as to what Dr. Rado means by the "non-disintegrative version of the Magnan sequence," or by "eidolic and reductive patterns." Expressions like these are assumed by Dr. Rado to be matters of common knowledge, whereas the meaning of the word "adaption" is spelled out for us in words of one syllable—well, two syllables!

Dr. Rado proposes the grouping of behavior disorders, that is to say, mental illness, into 7 classes and various types. I am tempted to go into a discussion of the necessity for scrupulous discrimination in regard to the distinction between classes and types. I am really more concerned about this than about certain words that Dr. Rado has chosen, which seem to me to be inept. Thus while I do not like the expression "lesional disorders," I am more concerned with the fact that to make this a class coordinate with a "class of overreaction" is to shift the *basis* of the classification, from one which is inferentially behavioristic to one which is specifically etiologic. Similarly it is, I believe, quite improper for Dr. Rado to base the first 3 or 4 classes of his classification on the pattern of energy control or, as he likes to call it, "dyscontrol," and then shift in the seventh class, "disorders of war adaptation" to the environment as the determinant of the pattern. And, incidentally, even assuming that Dr. Rado probably means "*battle* adaptation" rather than "*war* adaptation," so as to exclude some overzealous home-base activities which might be considered psychopathological, the fact remains that there is no more *theoretical* justification for setting up "battle adaptation" than there is for setting up "tornado adaptation," "storm-at-sea adaptation," or "Christmas rush adaptation," to say nothing of APA Convention adaptation!

Dr. Rado speaks of "emergency dyscontrol" and of "descending dyscontrol." Here my ears pricked up! While I do not use or quite understand these terms, I do think it important to recognize progressive stages of increasing disorganization of behavior, characterized by certain mechanisms and certain symptoms, the names of which are familiar to all of us, and to recognize too, that there is a *discoverable order in disorder!*

But just what Dr. Rado means by the expression "extractive disorders" (his class IV), about which he never has another word to say after the one sentence on that page, I have absolutely no idea. He indicates 2 types: "ingratiating extractive disorders" and "extortive extractive disorders." My own associations, I am chagrined to say, relate to dentists!

Dr. Rado is, I believe, endeavoring to use a new basis for classification, one which we all subscribe to in principle. We speak of it as the dynamic process basis. It was the discovery and ideas of Freud that gave impetus to this, although Freud himself never attempted a psychiatric classification. But Adolf Meyer did so, with great vision. Like Meyer, Dr. Rado discovers himself lacking in properly descriptive terms of generalization, and like Meyer, he makes the error of assuming that he can create words that will be immediately or at least ultimately recognized, understood, appreciated, and used.

Although these criticisms of detail are sharp, I have attempted to make them with a light touch. My comments do not disprove or even assail the validity of the basic idea that Dr. Rado is trying to express. As I have said, no one should be more sympathetic than I with the resistances encountered by any proposal to change the status quo of current psychiatric designations. Dr. Rado brings to this task his long experience and skill in one department of psychiatry, psychoanalysis. He has not been so closely identified with some of the broader problems of psychiatry, but we should welcome his interest in them and his contributions to them derived from his psychoanalytic experience. Perhaps, however, just because he is a psychoanalyst and knows so much about the

emotions and the unconscious, he should have better anticipated the resistances against which he would be speaking, and the effect of strange, obscure phrases and words on the ears of a defenseless audience. These may, in graduated doses, stimulate thinking and give rise to insight; but a barrage of such words and phrases is quickly subject to the law of diminishing returns. They are apt to inspire the wistful but baffled listener to wrap a mantle of protective indifference about him with an inward resignation to the continuance of his former unenlightened but familiar ways of thinking.

This we must not do. It was our great loss that we were not more receptive to what Southard and Adolf Meyer were trying to tell us 35 years ago. I believe with Dr. Rado that a better ordering of our thinking in regard to the disease process and the classification of those kinds of disease that we psychiatrists see is of the utmost importance to our science. We should be grateful to Dr. Rado for disturbing our complacency and for offering us suggestions for further progressive change. We must be glad he is thinking along these lines, and hope that he will continue it, changing his terminology, perhaps, so that we may better reap the benefit of the earnest and intensive thinking back of these prodigious efforts in a direction which is, I believe, a right one.

II. DISCUSSION OF DR. SANDOR RADO'S ACADEMIC LECTURE [1]

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Dr. Rado is far from being timorous ever, and especially when he commits himself to sustaining the proposition that a new etiological classification in psychiatry today must be based mainly on psychodynamics—or I should say on a new psychodynamics. It would be somewhat easier for me to discuss the ideas he advances if they were proposed separately as hypotheses for elaboration and testing. The way they are interwoven into a scheme of general classification and the suggestion that they should, in fact, be the basis of that classification makes the discussion more difficult. While Dr. Rado has not been able to present his whole classification very fully the outline indicates that a good deal of it has little direct relationship to psychodynamics.

Though my discussion will be concerned chiefly with what Dr. Rado terms "schizotypal disorder," I do wish to comment that I think we are not quite ready for a general psychiatric classification of disease and disorder on a very fully satisfactory psychodynamic basis. More than ever do I think this after hearing Dr. Menninger's discussion. In order to classify it is desirable to have simply stated diagnoses based on as certainly definable characteristics as possible. The application of psychodynamic theory in making diagnostic formulations sometimes tends to complicate the task of classification. We do not as yet have sufficient knowledge to enable us to present a fairly generally acceptable classification of psychodynamics itself, though headway is being made. Before I go on to a discussion of schizotypal disorder, I shall attempt to state some of the reasons why the framework of usable classification may provide too cramped quarters for the presentation of psychodynamic concepts. Psychodynamics itself requires more agreement as to the tenability of some of its propositions and consequently its own classification is not too well worked out. To select and use one or more of these propositions or a series of consecutively interdependent ones in their present state in a general psychiatric classification involves such serious difficulties that the prospect of very enduring value in the classification is not great. If the classification is set upon the basis of one or of an evolved series of related hypotheses, it must necessarily exclude hypotheses at variance with the ones advanced. Thus it may not leave storage room for new ideas. While older and simpler classifications may depend more on description of phenomena than on description of dynamics than the one proposed, they may be usable for a longer time because they serve the fundamental purpose of classification more clearly, namely, bringing together those classes that resemble one another and separating those that differ. The Kraepelinian classification has survived extraordinarily well as the backbone of succeeding ones. The introduction of still debatable hypotheses as the basis for classification except, tentatively, in very limited areas, tends to blur resemblances and differences in an annoying way that cannot be resolved by extended explanations.

Another problem is that of terminology. A new classification without new words is unthinkable and without precedent. Yet new terminology very often has a deciduous quality. The new words wither away from the old stem which next season sprouts a new crop. One can quarrel little with Adolf Meyer's psychobiological psychiatry. It is so clear that a neurologist in speaking to me about it once said that it is the expression of the obvious in complicated language. The ergasia terminology is little used now. Ten or 12 years ago most candidates for examination by the American Board of Psychiatry and Neurology tried to memorize it letter-perfect. This year some of the directors of that Board had trouble recalling much of it. I must say that in terminology Dr. Rado has sinned but little. The words he uses are all derived from roots with which we are famil-

[1] This article, together with the ones preceding and following, is a discussion of Dr. Sandor Rado's Academic Lecture, "Dynamics and Classification of Disordered Behavior," read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953, published on page 406 of this issue.

iar though they appear in some new combinations. At first glance, however, the terminology may seem to be strange because we have not been accustomed to using it in the way that Dr. Rado does. Therefore, his paper requires reading and re-reading. When one hears it on a single reading it may be difficult to grasp the essential concepts. On closer study of this paper it seems to me that these concepts appear very clearly. There is also a combination of spirit and logic in his whole idea that I like. I am only sorry that the bugaboos of classification—the old and common defects of this necessary scaffolding for the building of knowledge—should hamper its expression and prove tempting targets for the pot-shots of critics.

The spirit and logic housed in the structure justifies me in using a quotation from a favorite book of my friend, Dr. Bernard Alpers, Robert Hugh Benson's "Confessions of a Convert." Benson, speaking of the influence of his father, a clergyman, on his religious life, states: "I do not think, as I have said, that he made it easy to love God; but he did, undoubtedly, establish in my mind an ineradicable sense of a Moral Government in the Universe, of a tremendous power behind phenomena, of an austere and orderly dignity with which this Moral Power presented itself." Dr. Rado, within the limitations of the measurable portion of infinity where we may operate with the deterministic theories and methods of science, has attempted to establish in our minds an idea of the relationship of tremendous power to phenomena and the order that governs it well in healthy behavior and governs it ill in disordered behavior. This task is one that never will be completed as long as there is anything to discover—so we are far from its ending. I can admire the temerity of Dr. Rado in attempting it and would have the utmost charity and tolerance in stating what from my viewpoint seem defects in his endeavor.

No one may attempt a comprehensive consideration of mental disorder without giving major attention to "the group of schizophrenias"—to use Bleuler's phrase rather than the isolated word. To cover the Bleulerian range of meaning, Dr. Rado uses the termal schizotypal.

If I apprehend Dr. Rado's meaning correctly, his thought is about as follows: The unique type of alteration of thinking, feeling, and relation to the external world called schizophrenia by Bleuler is viewed by Rado in the light of genetic theory as inherited predisposition derived from both parents according to Mendelian mechanisms. He utilizes Dolzhansky's formulation of genotype (inherited cause of development) and phenotype (actual outcome of development in the organism through interaction with the environment). He takes for granted, as true, on the basis of fairly common opinion that there is genotype defect in persons subject to schizophrenic disorder and gives his chief attention to the phenotype outcome as the result of environmental interaction. The schizophrenic phenotype he abbreviates as *schizotype*. He believes that we can define schizotype from birth to death and that we may view the whole life history of the schizotype as a series of schizotypal changes following the laws of schizotypal dynamic organization. In the psychodynamic range this is the expression of the schizophrenic genotype. This whole nucleus theory is concisely stated and firmly knit together as a nucleus theory should be. It is to be noted that schizotypal organization is fated to be different from, and far less satisfactory in its developmental possibilities, than healthy organization. This difference is a proprioceptive one, the result in turn of an inherited predisposition—a proprioceptive diathesis, eventuating in proprioceptive disorder. One of the chief characteristics of this disorder is a distorted awareness of the bodily self. Prominently involved in the dynamics is an innate integrative pleasure deficiency, arising somehow in connection with inherited characteristics and certainly not, in Rado's view, primarily a result of environmental influence. The dynamics described is based mainly on these concepts of basic origins. The life of the schizotype is one of compensation under tremendous strain, operating largely through the use of unemotional thinking and the attempt at practicing a pleasure-scarcity economy with very little intermediate range in the fear–rage and defiance–obedience responses. There is lack of zest for life and poor counterbalancing of pain-connected emergency emotions. This is the theory then—a defective organism's hope of development and ad-

justment to life's strains lies in the ability to use substitutive compensations regularly. There is a special proneness to breakdown.

It might fairly be termed a theory of pessimism because it is so firmly committed to the hypothesis of hereditary defect. Therefore, it practically excludes other hypotheses except in very secondary roles—hypotheses such as those based on acquired physical defect and environmental origin of psychodynamic causation. Yet I am certain that opinion and some appearance of factual observation can be adduced to support these other propositions. Hypotheses such as those appearing with reference to psychosomatic disorder and the hereditary transmission of acquired characteristics suggest this. We are used to pessimism about schizophrenia. For a long time we were used to pessimism about general paresis, and I am sure Dr. Rado does not wish to overstress the pessimistic note. As to making compensation easier for the schizotype, to prevent breakdown, and as to aiding the recovery of compensation when it is impaired, he expresses a certain optimism. However, to accept his hypothesis as the basis for firm classification and to exclude 2 other leading hypotheses suggested for the same role seems to be without real advantage. I dislike limiting etiological classification in this manner until after we have a thoroughly provable hypothesis which is then established on the basis of scientific proof. Actually the serious limitation here is not the secondary psychodynamic one but the fundamental organic one of hereditary predisposition. Can we accept that as proved in schizophrenia? I doubt that it has been tested sufficiently, though it has long been advanced on the basis of expert opinion and on some evidence based on statistical genetic studies. Commonly held opinion, even common opinion of uncommonly qualified men, is not necessarily conclusive enough to justify full acceptance of an assumption. For centuries some men, uncommonly qualified for their time, believed that the earth was flat and that the sun revolved about it. Even such a false hypothesis was useful because its existence forced testing through the use of observable fact. Dr. Rado will ask nothing better than to have his hypothesis similarly tested, I am sure, especially as he hopes the observed facts will eventually confirm it. However, at this time, it would be better not to advance it as the major foundation of a classificational scheme. Neither am I convinced that etiological classification in psychiatry today must be based mainly on adaptational psychodynamics. It should be based on proved etiology. In spite of these criticisms, I am very certain that thinking such as Dr. Rado's will be a stimulus to research in genetics, physiology, and psychodynamics. The study of his paper has been a stimulus to my own thinking.

III. DISCUSSION OF DR. SANDOR RADO'S ACADEMIC LECTURE[1]

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At no time has it been more important than it is now that psychiatry be recognized again as a medical specialty. There is great need for psychiatry to acknowledge its integral dependence on physiology, pathology, and general medicine. Such an integration must be expressed not only in our practice, but in our attitudes, our philosophy, and our nomenclature.

It is also appropriate that psychoanalysts pay particular attention to this need for medical integration. Many have lost sight of the fact that Freud was primarily a physician interested in the physiological, chemical, and genetic approach to all disease, including those diseases that manifest themselves in disturbed behavior. In the first burst of enthusiasm for newly discovered facts of psychogenesis, and more than somewhat discouraged by the medical man's clinging to the solid rock of demonstrable pathology, psychoanalytic groups early encouraged a trend toward lay therapists. This effort to jump over the gibraltar of medical attitude has led us eventually to the brink of disaster, to a point at which mentally disturbed people can purchase "therapy" at the corner store, unprotected from the charlatan, the quack, the opportunist. It is high time that psychoanalysis found its way back to general medicine—perhaps we should say, time that psychoanalysis led the way back.

There is adequate evidence that many psychoanalysts are concerned with doing just that. Leadership in this movement must come from those psychoanalysts who work with other physicians in a hospital or clinic setting. The secluded couch of individual practice cannot provide the needed stimulus. Leadership will come from those who walk among their medical colleagues in the full light of day, sharing and sharing alike in responsibility for the care of the emotionally disturbed. Dr. Rado's effort at a dynamic classification of disordered behavior is a worthwhile move toward finding the way back.

The fact that Dr. Rado's effort has fallen somewhat short of his target is no reflection on the effort or the author. In its 4-year attempt to revise the old psychiatric nomenclature, the committee on nomenclature of this association came head-long against the same inability to meet its mark. The present new nomenclature of The American Psychiatric Association follows, as does that of Dr. Rado, the general nomenclatural scheme of Adolf Meyer, utilizes the names originated by Kraepelin and Bleuler, and incorporates the dynamics developed by Freud and later analysts, *wherever these are applicable.* In this last phrase is the crux of our problem.

As unpleasant as it may be, we must face the fact that the present body of substantiated data in psychiatry is quite limited. Beyond these limits each psychiatrist must develop his own frame of reference, and his own landmarks, in the nautical sense. That is to say, each psychiatrist must develop his own operational matrix. This he does on the basis of his own life experience, including his developmental history with all its emotional conflicts, as well as those points of reference he has absorbed from his teachers and from his clinical experience. It is for this reason that in psychiatry, more than in any other medical specialty, there is no substitute for clinical experience.

Thus we find each new psychiatric classification developing primarily out of its author's clinical background. Dr. Rado has had extensive experience with schizophrenia. It appears that he presents us a classification that basically is derived from observations on the schizophrenic person. I do not say this because he has concerned himself primarily with the schizotype today. This limitation was one imposed by the time element. Rather, I say this on the basis of having reviewed in detail his general plan of classification. The entire approach in this system has developed

[1] This paper and the 2 preceding are discussions of Dr. Sandor Rado's Academic Lecture, "Dynamics and Classification of Disordered Behavior," read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953, published on page 406 of this issue.

on a foundation of experience with schizophrenias.

Granted that schizophrenia is perhaps the biggest problem in psychiatry today, it is by no means the only problem. This, therefore, raises certain doubts about the entire scheme of classification, especially since it attempts to incorporate psychoanalytic dynamics, which were developed on clinical experience with psychoneuroses.

As a clinician, I do not find any difficulty in accepting Dr. Rado's clinical observations regarding the schizotype. I think Dr. Rado is to be complimented on reminding us that schizophrenia, more often than not, is a continuing process. This is an observation which Adolf Meyer summed up by saying that schizophrenia may be a way of life. But while Meyer saw in the schizoid personality a frequent forerunner of the schizophrenic psychosis, he did not clearly indicate the in-between stage of neurotic symptomatology which Dr. Rado has put into its proper context. It is appropriate to remind ourselves, however, that specificity of etiology for the clinical syndromes we call schizophrenia has not been demonstrated.

It seems unfair to be critical of this one small section of a broad point of view. Dr. Rado has presented, in 40 minutes, ideas which he has formulated in 10 years of clinical work. This is bound to produce some distortion in the ideas as heard by the listener. He has utilized new words, which always makes understanding difficult. I am not at all sure that this is unwise, because many of the old words carry with them historical connotations for all of us; these connotations themselves give rise to parataxic distortions in our diagnostic approach. I do object strongly to the substitution of such words as "self-reporting" for "conscious," and "non-reporting" for "unconscious." This seems to me to be an unnecessary complication.

It should be underlined that Dr. Rado considers the characteristics of the schizotype on a sliding scale, and has presented to us only the most marked degree of schizo-adaptation. The nuances must be remembered to make this approach maximally effective.

With the matter of integrative pleasure deficiency, this seems to be a constitutional approach to the characteristic formally known as narcissism. Rado considers this an innate defect. While we may *suspect* that he is right, we must ask if this characteristic could be symptomatic.

I can agree easily with Rado's observations concerning the strength of the emergency emotions (fear and rage), and the resulting emotional imbalance. I also find agreement with the correctional steps which the schizotype attempts: the scarcity economy of pleasure, with clinging to any pleasurable experience, the compensatory dependence, with all its accompanying hostilities, and the shift to unemotional thought. Regardless of other considerations, from a clinical point of view, this is the way a schizophrene lives.

It seems to me that we owe Dr. Rado a vote of thanks for focusing our attention on the proprioceptive disorder in schizophrenics. This is the attribute of the schizophrene most often overlooked by the resident and the inexperienced in psychiatry. In the presence of this proprioceptive disorder, the parental, or surrogate-parental, task of maintaining a satisfactory two-way relationship with the schizotype becomes almost impossible of accomplishment. We hear much about the schizophrenogenic mother in our clinical conferences, but little about the child who evokes traumatizing responses from his parents. Dr. Rado's discussion of the schizotype brings us back to a basic consideration, namely, that man is not putty in the hands of his environment, but from the time of his birth has much to say about what happens to him, and much responsibility for it, the transactional point of view.

Finally, I would like to pose 3 questions for consideration: (1) Can a classification scheme derived from schizophrenia be expanded safely to general application? (2) Are there data to support the dogmatic statement that the integrative pleasure deficiency of the schizotype is innate and not symptomatic? (3) And this is basic to the validity of the classification: Are the characteristics here attributed to the schizotype exclusively differentiating, or do they occur elsewhere in disordered behavior?

ORDER / DISORDER

EUGEN KAHN, M. D., Houston, Texas

The psychiatrist, indeed every observing person, is familiar with a certain kind of people that I am going to describe briefly. They are characterized by an extreme meticulousness which, as it were, hits one's eye at first sight. They always seem to have washed and shaved just a moment ago. There is not a speck of dust on their well kept clothes. This meticulousness is manifested in their appearance and permeates many or even all their activities, their work as well as their recreation and their hours of rest. Some of them can be considered as living clocks after whom one can set his own watch as day by day they turn around the same corner on the way to the job—and on the way home—at the very same minute.

I am not now thinking of any actual pathology that may play a role in these meticulous people, but pass on with the statement that their punctiliousness is not only a striking feature in their behavior, but a definite asset of their personalities and an asset for their environment. Yet once in awhile we may find them slightly annoying and possibly think that the very exactness with which they perform appears to be more important to them than the performance itself.

What may this meticulousness or punctiliousness or exactitude be and mean for these people and for us? Is this meticulousness or punctiliousness or exactitude just a more or less funny streak in some people, or is it a particularly outspoken manifestation of some rather profound and general principle? I want to anticipate that in my opinion the latter is the case, and that the apparently conspicuous behavior patterns of meticulousness or punctiliousness or exactitude are but peculiar expressions of what one may properly call the sense of order which itself is intrinsically tied up with the principle of order.

What do we see if we look at any part of the physical world that surrounds us and in which we live? We see that, for all we are able to perceive, matter is arranged in some way or other. I do not go here into the metaphysical question if there is any matter at all, but take it for granted that for our purpose we can use the concept of matter without running into any logical mistakes. There is matter. There is stuff around us, as I have just said, arranged in certain ways. We see stones. We see hills. We see mountains—very hard and firm matter whose arrangement does not change at all while we look at it even if we do so for a considerable span of time. We may, of course, happen to be witnesses to a hurricane or to an earthquake which will very intensely disturb the physical arrangement of our surroundings, may cut big holes into or even shatter the very firmest and largest aggregation of matter. But matter again falls into some arrangement, and for a span of time the new arrangement, whatever it may be, remains undisturbed. A little heap of steel filings falls into the perfect order of a magnetic field. If we follow the teachings of physics and of chemistry, and look behind the macroscopic order of matter, we learn that there are definite, very minute arrangements: atoms, molecules, chemical compounds, and what not, which have a certain stability, and which, if for any cause this stability is altered, undergo changes in an orderly way, according to what is called natural laws. There are the sun and the moon, the earth and other stars on their ordered way; but comets appear and cosmic catastrophes occur, obviously and sometimes profoundly disturbing the existing order.

Order is no less impressive when we turn to the organic, or more specifically to the biological aspect of our world, focussing our attention on the plants and animals. There is a definite, if exceedingly varied structure in all things living, from the simplest plant and animal on upwards. Furthermore in the development of structure and function of any living thing, plant or creature, a developmental sequence can be observed, that is, there are well recognizable patterns in their development. Under ever so many conditions such a developmental pattern can be interrupted for a while; in many instances the plant or animal then, as it were through an endeavor of its own, tends to come back to an orderly development. The patterning in

the embryonal and fetal development of animals, including man, is a magnificient demonstration of evolutional order. As regards developmental sequence and order, one has to think of the evolution of the species which has often been thrown out of order catastrophically but made a comeback every time when new forms of flora and fauna appeared with new structural and functional and developmental patterns fitting in somehow with the physical background that had been upset for a time by a cosmic upheaval and afterwards had come to a quite orderly, if novel, equilibrium. Equilibrium, in general, is order too.

What has been said about plants and animals at large and about species holds true for all the smaller and larger groups and classes between them; there are larger and smaller groups whose structure, development, and ways of life follow the same lines, are more or less of the same order—birds of one feather. It is obvious that facts like these have been instrumental in all scientific attempts at and establishments of classifications in botany and zoology and that they have helped to find and to buttress a number of the so-called natural laws. One might say that classifications are no doubt constructions of the human mind and add that the natural laws founded on them might be only little more. It would be but a small step to the notion that the concept of order, which may be a bit vaguely conceived anyway, and order *per se* might also belong to that large body of human inventions. That our concepts are human conceptions or inventions cannot be argued; that does not imply, however, that facts on which concepts are based would not be facts. I am of the opinion that order—what we call order—was impressed on man from every direction, in every field of work or play. Day and night, the tides, and the seasons brought home the very fact of order and rhythm. Even if man would have tried wilfully to ignore order he could not possibly have done it for a long while. From being impressed with an ever and always present fact—the fact of order—to the formulation of a concept—the concept of order—was not a very long way presumably. But regardless of the formulation of the concept, order itself could never be forgotten or be overlooked by man for the simple reason that he needs, always and everywhere, order. To say it very pointedly: without some sort and degree of order, man is not able to exist. The human need for order varies as to degree in human individuals and in human groups. Some individuals have, for longer or shorter periods of time or throughout their lives, an exaggerated need for order—so have groups.

Let me restate the problem. I conceive of the world in which we live and experience, and after a time die, as a unit, a very large and great unit indeed, in which a number of principles appear to be working. One of these principles is order, order not only in form or structure, but order also in movement, development and change, *i.e.*, order in space as well as in time. A simple example only is a railroad train leaving a certain place at a certain scheduled hour, and due to arrive and, if nothing adverse happens on its way, actually arriving according to schedule at another place at a certain time. If I want to go from the first to the second place with this train, I have to make arrangements accordingly; I have to fall in with the schedule, with the timetable, with the order as determined by the railroad company, unless I am royalty and can commandeer a special train, compelling the railroad company to fall in with my royal order. The railroad company, though, making out the timetable has to consider the needs of its presumable clientele—it cannot, *e.g.*, run trains for people going to work and coming home, say, at midnight. On the basis of a large number and variety of factors, a timetable is established suiting the needs of an often very numerous, if diversified, group of people.

The ubiquity of order in human life can be followed, and as a matter of fact is being followed, from a number of angles and in any number of ways, some of which I may mention. The historian trying to draw a picture of a period of the past proceeds methodically, and sooner or later comes to the appreciation of certain threads of historical development characterizing the period under consideration in its static and dynamic aspects. The biologist, in whichever special field he is working, always starts from premises concerning structure, function, and development of his objects, and will even if he were profoundly antagonistic against the concept of order, always find manifestations and be-

haviors according to patterns; there may be a multitude of patterns but they appear again and again. The sociologist, working, say, in the slums of a very big city, is bound to meet and trace all kinds of facts and factors which in the long run are explainable and even understandable in pretty orderly fashion and in which and behind which definite patterns can be recognized. The physical anthropologist, whatever his attitude towards racial problems may be, finds all sorts of bodily qualities, some of them fairly measurable, and most of them representing definite patterns. The cultural anthropologist, working in primitive or in complex societies, may at the start be overwhelmed with the variety and multitude of mores, that is, behavior patterns; after a time he finds that such patterns occur in many groups and do not seem to run at random but to evolve in a more or less orderly fashion. Concerning the psychiatrist's field of work, I will have to make some observations later on.

One may wonder whether I overestimate order and try to read order into things, into events, and into experiences that may not be so very orderly, but rather disorderly. One may especially think so if he takes a short glance at the present political scene on this continent and a few other continents. One might say that there is so much unrest, dissatisfaction, disillusionment, in some quarters even so much pessimism and hopelessness, that at least today, to make a pun, order does not seem to be the order of the day. Whatever ideas one may hold about political systems, is it not already clear that older systems have become somewhat shaky and disorderly, and is it too bold to surmise that new systems are in the making with which man essays to establish another order—for better or worse, we do not know?

So far I have emphasized order, but I do not overestimate and do not overemphasize it. Indeed I have repeatedly mentioned and alluded to the fact that any order—physical, biological, and social—can be interrupted, can be broken down by occurrences that cause disorder. I have remarked on hurricanes, earthquakes, cosmic catastrophes, interruptions in the biological development of individual creatures and of the species; I have alluded to world-wide unrest. There is, as a matter of course, disorder everywhere and at all times as well as order. I will go so far as to claim that there would not be any order without disorder, and there would certainly not be the human need for order if it were not continually kept awake by actual disorder and by our very experience of disorder. Moreover, any event may be experienced as orderly by an individual or even by a group that another individual or another group may experience as definitely disturbing his or their order. This is so obviously true in the sphere of politics—national and international—that many of us can scarcely believe it. In other words one man's meat is another man's poison; one man's order may be and often is another man's disorder. There are quantitative as well as qualitative differences in the appreciation of order and disorder respectively, by individuals and by groups. If this were not the case, all of us might be "living clocks" and nobody would find those whom we consider as "living clocks" in any way conspicuous or peculiar. Or all of us might be equally neglectful of ourselves and our physical and social surroundings and nobody would care. But some always do. I would venture the guess that a spider, if he were capable of the necessary mental acrobatics, would proudly enjoy his cobweb as the peak of order and deem the bee and the butterfly and their ways of life terribly disorderly, whereas these two would be likely to consider a cobweb a disorderly mess especially when finding themselves caught in it.

Order and disorder exist and can be seen anywhere. Human beings in general are able to experience order as well as disorder. Let us presume that a person, an entirely "normal" person, is living in a certain situation. Mr. X, a 35-year-old professional man, is happily married, father of two healthy children. He owns a home, has a permanent position with a satisfactory income, and is doing what he feels and his superiors consider to be a good job. Everything is going fine. There are no flies in the ointment and no black clouds in the sky. Everything is in order. Work and income, education of the children, family life, recreation, and rest are sensibly organized. Everything in this little family is in order. They live in harmony with

parents, in-laws, and other relatives. Such situations, surprising as it may be, really exist. One may ask how long? Mr. X may get sick. So may his wife. One of the kids may have an accident. A relative may die. Unexpected expense may have to be met. An insurance policy may have to be increased. A new co-worker, perhaps a superior, in the organization may be unpleasant and give Mr. X a hard time. Such examples can easily be multiplied; they all mean fundamentally the same. Some disorder is being brought into a so far well-ordered situation. Let us assume that Mr. X and his wife master the difficulty —indeed master a number of difficulties as many people have to do and do. Other difficulties may crop up again and again, disturbing the ship-shape order they had been enjoying before. What has happened, and what does this mean? Mr. X had been fortunate in his personal and social life thanks to the fact that it was so well ordered and his family for quite a time were enabled to enjoy a high degree of security. Then disturbance, disorder, comes along. Their security is disturbed for a longer or shorter time, is disturbed again and again and may even be, if things develop very badly, definitely shattered. *Order means security.* Disorder—any kind of disorder—threatens the security, threatens the very sense of security of the individual or of the group concerned. The group may be a family. The group may be a nation. The group may be a race. Threat to security implicitly arouses fear or anxiety which in its turn may lead to all kinds of disequilibrium or disorder.

The picture of the X family may appear to be idealized. We have, of course, to add that a man in our culture or in any other culture for that matter, is not likely to reach the age of 35 years without ever having experienced some insecurity, some threat or actual disturbance of his order. Nor would that be desirable, if I am right in my contention that disorder is fundamentally responsible for the human need for order. It is a necessity in the development of the human being to live through all manner of disorder and order, finding himself more or less unbalanced once in a while, coming back to his feet, working and enjoying himself but laboring and once in a while suffering too.

In a few previous remarks I have alluded to order in the development of the individual. Some elaboration I think is in place here. One is accumulating a host of knowledge since a goodly number of years concerning the development of the child. Under "normal" conditions the healthy child of healthy parents develops almost according to schedule. Movements, responses to the environment, language, emotions, intelligence, and so on, evolve at certain times and this development proceeds in a most remarkable order. A multitude of even minute disturbances, however—disturbances from within or without—may for a longer or shorter while, interrupt the orderly development of the infant and may, in not so few instances, leave on him and his further development definite traces with far reaching consequences as to his ultimate development and as to his final adjustment in and with his group. The more such undesirable disturbing influences can be kept away from the child, the less likely it is that his early and later development be seriously or dangerously handicapped. The earlier many of such disturbances and their effect on the child are observed, and the earlier something is done about them, the greater is the child's chance fairly smoothly to slip back into his orderly development and to overcome the effects of the disturbance.

No child, however, could or should be pampered too much. No child should at all times be wrapped in cotton. No child should or could at all times and in all stages of his development be anxiously kept away from contact with the "hostile" environment. A bump on the head may act as a good stimulus in a healthy child; but I would, of course, advise nobody to hit a child on the head. As life is on the whole rather a serious business comprising order and disorder, we should remain aware of the desirability and necessity for the child to get to know his world as *it is* for him and not only as he and we may be tempted to make it appear to him. In the child's world order plays a considerable role, as Lawrence K. Frank put it: "Children love order, regularity, repetition of the same pattern endlessly, and they need consistent adult guidance and help in learning these patterns of what is essential to their adult life and social living." In the developing and shaping of patterns and habits—habits, inci-

dentally, have been defined as "regulated ways of life" (W. I. Thomas)—the emotional situation of the home is of utmost importance. The child perceives the world through the emotional atmosphere of his home. Children of happily mated parents have a better chance to grow up in order than the offspring of an unhappily married couple. Even if the child does not *see* that his parents do not get along well with one another, and if he does not *hear* them quarreling, he *feels* what the lay of the land is. He may during the earliest period of his life become disturbed in his order, he will in his way experience the threat to his security stemming from the emotional instability of his immediate surroundings. Trouble with food intake and digestion, with sleep and play and many other things can develop on such a basis. Some of these manifestations, tied up with anxiety, may become deeply rooted and develop into permanent habits and attitudes chronically handicapping the development of the individual. There are quite a few people who were so badly frustrated in their need for order and security very early in life that they become and remain unable socially to adjust in a manner satisfactory to themselves and to their environment. Adjustment, whatever else it may signify, means in our connection falling in with the order of the environment. Maladjustment in our connection means unpreparedness, unwillingness or inability to fall in with the order of the environment whatever the special manifestations of maladjustment may be and whatever the special aspects of the social order may be concerning which the individual's attitude becomes conspicuous.

People do not come to the doctor for advice with statements like, "I experience a lack of security," or "I think that my need for order is not satisfied." What we are faced with as physicians, particularly as psychiatrists, are people with any sort and number of complaints, with an immense variety of "clinical pictures," with all manner of symptoms, of ideas, with anxiety in concealed and unconcealed form of which often enough the patients are not aware at all, and of whose sources, in most instances, they are entirely ignorant. Examining them, getting the history of their lives, analyzing their reports and their situations, one scarcely ever fails to find that sometime and somewhere, maybe repeatedly, their need for security, their sense and need for order, had been badly disturbed. One finds that wishes and ambitions, mostly *per se* quite legitimate ones, had been frustrated; that instead of being allowed naturally and freely, if orderly, to develop towards enjoyment and work and service in their group, they have been unfortunately, if unintentionally, trained not to trust themselves and to regard the world as a poor, shady, and shaky place to live in. According to their light, or lack of light, they have learned just to duck under and crumble, or they have acquired a protesting, rebelling, and fighting attitude, being unable or disinclined to make compromises which are necessary in ordinary and ordered group life. Some of these rebels become theoretical or practical protagonists in any conceivable kind of revolutionary—or pseudorevolutionary—movement, chronic disturbers of the existing order of the group. A few are highly successful at the revolutionary game. That they ever become happy one will doubt as much as their mostly overloud claim of being the warmest friends of their fellowmen. It is in fact their personal prestige and power in which they are foremost, if not exclusively, interested. Whatever aim they may obtain, the feeling and enjoyment of security appears to be denied to them.

In our work we are dealing with any number of people who have neither the ability, *e.g.*, certain feebleminded, nor the chance, *e.g.*, some juvenile delinquents, to enjoy a development of their personalities in the group appropriate to their personal need for order and appropriate to the group's need for order. Not all disorders of personality, minor and major ones, are due only to psychological and social factors; indeed bodily factors are very often found to play some role. There are morphological deficiencies and diseases of the central nervous system that are bound to disturb the orderly development of the individual even under most favorable social circumstances. So do certain so-called mental diseases of whose nature and etiology we do not know much as yet. So do, in their ways, a broken leg or an appendicitis or a pneumonia. Wherever the supposedly leading factors may be sought or found, regard-

less of whether in a given case we have to give a certain emphasis to bodily or psychological or social factors, we look at and appreciate always the whole person in his special and specific situation, and only in doing this can we come to an intelligent and fair appreciation of the real meaning of this person's disorder and possibly of the conditions under which his order became disturbed.

In psychiatry many of us have accustomed ourselves during recent years to talk of personality disorders instead of using terms like psychoses, psychoneuroses, or neuroses. I think that this development, which might at first sight be regarded as a terminological whim, has a definite significance. It emphasizes that it is always the person with whom we have to deal, and it implies that there is some disorder in or with the person about which something has to be done and in most instances can be done. We no longer allow ourselves to be overly impressed with Greek hundred-dollar words of our own or other people's coinage. These personality disorders can rest on any combination of dynamic factors; I understand by dynamic factors anything within and without the person that is working on him physically or psychologically or socially.

The person is possessed of some sort of inner organization according to his original endowment and according to all factors that have been working upon him from within and without. His organization from the very beginning, as already indicated, is to a great extent influenced or modified by the cultural and social attitudes of his group, attitudes of which for him, his parents or his whole family are naturally the first representatives. In this connection one may consider what *e.g.* language means for the whole development of the human being. That the individual as an organism is immediately able to make noises, and comes to use such noises in one way or another, does not primarily depend on influences from the outside; many animals are possessed of this aptitude, but animals never learn to speak. It is the human-cultural-social medium in and from which the growing child learns to speak. Language is a social-cultural aspect of the personality in which or with which many disturbances from within and without can find a variety of expressions. Examples: there are people whose vocabulary and grammar will always be poor. These are people who never are able to express themselves easily in the presence of a group. There are stutterers and stammerers. There are people who get hoarse or even mute if they are under certain strains or in certain situations. With all our assumptions of the intrapersonal assets and liabilities of the individual, we can never fail to see that his assets and liabilities play under the influence of his environment, and we should never forget to realize how immensely complex this environment is. Not equally complex of course for all people even if they happen to be in apparently the same situation. Order for one person may mean disorder for another person. A singer, *e.g.*, may be fully at ease, when he is faced with a large audience; in apparently the same situation another person called upon to sing a few bars may get into a panic.

The orderly development of the individual, exposed to any number of disturbances everywhere and at all times, undergoes in the lives of individuals critical periods of disorder in which any degree of disorder is apt to arise, as it were, only or predominantly on physiological grounds. There is the adolescent. Even if an adolescent person develops rather straight through this critical period, as a person he undergoes considerable change; the boy's voice breaks, he grows a beard, there are pointed changes in his psychosexuality. The girl begins to menstruate; she becomes a young woman. Boy and girl not only change within, but on the ground of these inner changes their whole outlook undergoes a profound alteration. These facts in a number of societies have led to a variety of initiation rites through which youth is officially terminated and admission into the adult group celebrated. Incidentally, the intertwining of physiological, personal, cultural, and social factors of such rites is immensely telling. In our culture we see little, if anything, of such initiation rites but rather a number of difficulties with which the youngsters and their elders are faced. On one side it is not always easy for the young people to adjust themselves during this period, and on the other side many of their elders find it painful to see "the kids grow up."

Let us not forget that "normally" during this time children begin to develop their independence of their parents, and troubles and conflicts come along galore. One is rather satisfied to see that adolescents kick up their heels a bit, give visible expressions to the turmoil, *i.e.*, disorder, through which they go. On the other side one grows uneasy when some of them take these changes, as it were, lying down without any revolt towards the environment. If there must be rebellion in the individual's life, the group for its own order and security likes it best or dislikes it least to occur during adolescence, expecting for good reasons that most of the youngsters will "settle down" soon. One well-known disorder rather characteristic of the adolescent period has been called *Weltschmerz* in German; this can be translated "world despair" or "cosmic despair." A weird sort of general dissatisfaction, gloom, and hopelessness takes hold of the young person. He or she feels sure that he or she is no good at all and will never be able to make the grade. He or she may fall in love, which is sometimes unrequited, and about which he or she knows not what to do. Such disturbances may last for a while; fortunately many youngsters overcome them practically on their own power. But a few get caught in it, break down, and even may commit suicide.

In another physiological setting, namely, the climacteric, gloominess may take hold of the individual for a considerable span of time too. During this period of life we see cultural influences most impressively at work. There are always some friendly neighbors who would tell a woman that she is up against a hard time and that some women become "insane" during the change of life. During this period of life which is marshalled very well by the vast majority of women, very undesirable influences—prejudice, ignorance, superstition—from the outside are once in a while among the factors bringing about personality disorder when a person *per se* might have been able to go through this period without any appreciable disturbance. Not every physiological change, of course, need bring about or does bring about a personality disorder; we can consider it a fact, though, that in personality disorders during the menopause, besides personal liabilities, the experience of cultural factors plays a role.

Analogous remarks can be made concerning the process of aging. That we do not get more vigorous and that in general our memory and other mental capacities do not grow more powerful as we grow older is a matter of fact. Yet ever so many people are able to grow old in dignity although some of their capacities more or less slowly fail. This is not the case in persons who have hypochondriacal leanings and who are observing the development of their alleged or actual arteriosclerosis with a queer curiosity, say, from age 40 on. They are due for all manner of disorders. They estrange themselves from the group in an often almost violent manner and afterwards resent very highly that, as they see it, the group has "dropped" them.

And ultimately death gets us all. Death and fear of death and death wishes have been much discussed during recent years. No doubt many people are afraid of death most of the time, and there is probably nobody who would not experience some fear of death once in a while. Death after all is the end of the person's existence and means dissolution. It is noticeable, though, that ever so many people when they really come to die seem to take it reasonably and seem to die rather quietly. We might say that they leave an order in which they had been existing for some time—that they go as individuals into disintegration, *i.e.*, disorder, but that their personal dissolution leads, in the physical and biological sense, to new orders—energy and matter, as the physicists tell us, never get lost and will again and again become organized in other patterns.

Some of the so-called major disorders of personality, the acute and chronic ones, the benign and malignant ones, deserve mention in this discussion. In patients suffering of such major personality disorders the interplay of inner and outer factors upsetting their order is mostly very obvious. Any such major disorder brings about a more or less outspoken disorganization of the individual; the disorganization within by necessity leads to a conflict with the order without. Some patients withdraw from their actual situation and build up a world of their own, a new personal order, if you want to say so. Some go so far as to work out their own system of

ideas, delusions they are sometimes called, which not too rarely remind one of philosophical, political, and religious systems as they culturally develop in small and large groups. A few of our patients find a sort of peace in their new order—as groups might find comfort and security in political and religious systems. Some patients from the very beginning of a serious personality disorder come to clashes with their environment which they feel is hostile towards them and which unfortunately in not a few instances actually grows hostile in response to the patients' aggressive behavior. The consequences as to the person's place in his group are easily understood. It is a great progress in our field that our psychiatric institutions make every effort to do everything possible as regards the socialization or resocialization of such people. This means definite endeavors to help the sick to find their way back to the social order in which they formerly had lived a more or less well-adjusted life—a life that in at least some ways had dovetailed with the order of their group.

Not only people with personality disorders but people with all kinds of bodily ailments and illnesses on account of transitory or chronic disability lose their place in the group —fall out of the group's order. It is encouraging to see that our medical profession is aware of this and that the treatment of the person in his and according to his situation makes headway in every field of medicine. It is recognized that it does not suffice to take out an appendix and send the patient on his way, but that it is better to prepare the patient in a sensible way for the operation and for the convalescence and to stand by when he goes back to his home and his job. *Disease always means disorder.* Many people can take it and fight their way through well; some are caught at times not so much in the disease itself as during the period of convalescence; they become afraid of the day when they will have to shoulder all their responsibilities again and when the excuse of being sick, which once in a while has its great advantages, will be taken away from them. May it be said once more that social factors of all kinds are always of some and often of great import in these situations. The individual is always unique and his situation is unique also, even if he is well organized and well adjusted in his group. In most instances an individual's disease entails disorder not only for him but for his family and possibly for a larger social group. The movement to spread health insurance indicates the increasing realization that disease—disorder—threatens security. This is not a novel idea. Health insurance is a cultural pattern appearing and being developed in the setting of industrial and technical evolution of society.

We turn once more to patterns in the individual's life. Behavior patterns or habits commence to be formed in organisms that are not yet fully organized. If they develop favorably, they fall in step with the individual's biological development which is somewhat ordered and in which well-observable rhythms occur—rhythms make for order, too. The heartbeat is a rhythm which throughout life definitely tends to run on, being clearly influenced and changed by factors from within and without. Other rhythms are observable in eating and digesting, drinking and voiding, movement and repose. It is understood that training—early training—is of paramount importance to bring these and other rhythms in line with the behavior patterns of the group at large. This connects with the child's need for orientation in time and space, with his need for order. Children always have to ask innumerable questions clearly showing how eager they are to find their bearings. The often discussed sexual curiosity of children is one aspect of their attempt to orient themselves—children have got to know whence they came and where they are going. Do no adults have corresponding curiosities?

Considering rhythms one will realize that the rhythms within and the rhythms without do not always perfectly conform among themselves or with one another, respectively. Various rhythms can, so to speak, be at cross purposes. The relationships and interrelationships of rhythms may be disturbed and the personal and social equilibrium of the person be threatened. Under "normal" circumstances, the human individual is able to keep up a certain balance well enough. This balance in some people is utterly labile, and it needs only very slight jarring from within or without to upset it. Then disorder prevails from which the individual in his own ways makes an attempt to come back to some balance or order. The lesser the imbalance was and the less it had altered the individ-

ual's place and relationships in his group, the more likely is he pretty soon to find his equilibrium again. There is a certain hierarchy of interpersonal relationships in the group (parents, siblings, relatives, class, caste, sex, age, and so on), somewhat varying in different cultures. The more serious the individual's inner order was disrupted and the more intensely his relationships in the group were broken, the more help does he need for the sake of his re-establishment in the social situation. The destruction of inner and outer order can be or become so great that a full re-establishment is impossible. But in a goodly number of apparently extremely severe instances, one is able to offer help; in some patients one can elicit a spark of confidence from which they will derive the feeling that at least they are not outcasts but do and are considered to belong to the group although they are not in a position to function and perform to the degree in which more fortunate group members function and perform. There are patients, who after losing ground in the community at large, find a little niche in an institution where, albeit not leading "the full life," they are at least enabled to enjoy quietude and more than a modest degree of contentedness. I would say that a number of such people when they have attained a reasonable amount of intrainstitutional adjustment will be happier in remaining in the institution because their return to their community is likely to jeopardize the relative balance they have attained, to throw them into a new turmoil, to endanger themselves and also the order of the community. In many cases patients who had lost their balance in one way or another are capable of being resocialized during their stay in an institution to a degree which allows them to rejoin their group and to fit themselves into its order for years to come, or even for the rest of their lives.

Order and disorder are a jealous couple, always wrestling, as it were, for supremacy in the individual and in groups. There is, almost by definition, no static order possible in life—change is natural and necessary. The order of yesterday may be the disorder of today or vice versa. What one person or one group considers order may be adjudged disorder by another individual or by another group. There are not a few apparent paradoxes. Revolutions seem to be disorder—some, however, proceed methodically and orderly. Revolutionaries are not exclusively people "without order"; Robespierre, *e.g.*, was a "living clock," an outstanding perfectionist and pedant, who attempted to rule and thoroughly to regulate every aspect of the life of the individual and the state. Disease, we said, means always disorder; yet some disease processes proceed in an unbreakably orderly fashion. There is a varying degree of order in disintegration once in a while. Crime, although considered a social disorder, is often well organized; one reads of criminal organizations which are or were as well organized as big business or a government department.

We see often that individuals and groups suffer from a lack of order. We see also that exaggerated order can cramp a person and a group. Too great order leads in individuals to formalism, to mannerisms, to rigidity—to order for order's sake, an order ultimately meaningless in the living relationship between individual and group. Too much order in society—in tribes or nations—leads to rules and regulations on end, to regimentation of all activities, to overritualizations to the effect that the ritual is being worshipped *per se* regardless of what its original meaning may have been.

In persons and groups such rigidity or overritualization may bring about a break—once in a while a chaotic break from which individual and group may be unable to extricate themselves. Chaos is complete disorder in which individuals and groups perish. But once in a while something is saved even from chaos—new life with new order may originate from an ash heap as well as from a few bewildered survivors of a group that had perished in a cataclysm. Our own earth, after many a catastrophe, was again and again the soil of new life, of new organisms and species, and of new orders in the life of man.

Realizing all this, we may find comfort and a certain hazy feeling of security so that without misgivings and discouragement we can stick to our immediate task, that is, to try to help those who are unable to gain their share of a feeling of security that would enable them successfully to fight their way through the Scylla and Charybdis of order and disorder.

THE IMPLICATIONS OF THE PSYCHOGENETIC HYPOTHESIS FOR MENTAL HYGIENE[1]

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The responsibility of medicine and its allied sciences for the cultural life of the peoples of the world has been enlarging for centuries. Doctors seem always to have had access to the personal facts of their patients lives and to have had advice-giving and comforting functions granted them; this is most apparent in the almost legendary figure of the old-fashioned general practitioner so prevalent in our present-day culture in this country. The calm expectancy with which parents look toward the immunization of their children represents quite a new pattern that is culture-wide in its penetration. The recent struggles over whether or not water supplies shall be fluorinated have indicated that the recommendations of medical scientists can and do override objections based, rightly or wrongly, on religious grounds or grounds of political freedom of the individual to do what he wishes with his own body. For the mass of the population, medicine is given the power and the responsibility of invading the body with chemicals and robbing it of blood for tests, of knowing the secrets of the history of that body and of arranging a suitable future for it. In these areas and many others, medicine has initiated widespread and quite fundamental cultural changes and must bear some responsibility for these changes.

The psychiatrist, as a medical specialist, has had tremendous cultural impact as well. Although we may deplore what is considered a low level of public education about our area of medicine, it cannot be denied that there has been tremendous advance. Though its thinking may be confused, there is a large segment of the population that recognizes that psychiatrists have a place in criminology. Particularly in juvenile delinquency, the public grants that there must be a factor of abnormal function of human behavioral restraints that requires medical attention as well as discipline and retribution. However much importance one may wish to ascribe to the changes in housing and the mobility of the population, the fact remains that, in our culture, attitudes toward psychiatric hospitals have changed so that families are able to bring themselves to hospitalize these behaviorally sick members. Granting all other factors contributing to the increasing willingness to hospitalize, it can hardly be denied that the public has changed its attitudes to a degree and that psychiatrists bear a considerable responsibility in having fostered this basic cultural attitude that is effective within the basic social unit—the family itself.

Psychiatry is that specialty of medicine that seeks to understand and cure such mental diseases as it can, and to be responsible for the continued care of those patients who cannot be cured with methods now available. The psychiatrist deals with people who are complaining or who are complained about. Mental hygiene is that branch of science that attempts to use the understanding of the psychiatrist, the pediatrician, the psychologist, the anthropologist, the educator, the public health worker, and others in devising means to promote the healthy growth of the personality, either through removing obstacles to that growth or through improving the situation in which it takes place. While it is usually taken for granted that the latter has some effect in preventing later breakdown into disease, this is not a *sine qua non* of the theory of mental hygiene.

Perhaps an analogy will make the meaning more clear. The psychiatrist, were he dealing with corn, would be concerned about how to get rid of the corn borer in the ear and heal the damage already done. The mental hygienist would be at work trying to rid the environment of borers and to find a way to get the corn to grow so that the borer could not enter the ear. To do so, he might try to

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eradicate the borer or he might try to find a way to grow the corn so othat it would be mature before the borer was around. He might try to influence the corn so that it would not be appetizing to the borer. Or he might try to prevent any injury or disease to the growing corn that would make it more susceptible to infection. It is a deceptively simple analogy, but it will perhaps make the thinking clear.

Mental hygiene is primarily concerned with healthful emotional living and the prevention of psychiatric illness rather than with the therapy of persons already ill. It has 2 main avenues of work. The first has to do with the prevention of those psychiatric illnesses secondary to damage of the central nervous system. The only numerically important mental illness statistically proven to be preventable is paresis, in which the primary etiology is infection. It is mental hygiene to cure syphilis early, to prevent and to cure meningococcus meningitis, to prevent developmental anomalies, including mental deficiency, by protecting pregnant women from German measles. Such mental hygiene presents few theoretical problems for public health administrators or physicians. Not all the problems are solved, but the methodology is reasonably clear and the research problems are at least familiar.

The second avenue of work in mental hygiene deals with the hypothesis of psychologic determinism and of its psychiatric derivative, psychogenesis. Psychologic determinism in simplest statement means that the emotional and intellectual experiences through which an individual passes in the course of his development from the zygote to corpse make a difference in his mental functioning. There is no doubt of the truth of this concept in general. Everyone agrees that a person is different after he learns things in school classes or in the school of life. In man the process is so complicated and deals with so many avenues of learning that it frequently requires difficult and complicated experiments to show the effect of particular types of teaching in particular settings. Frequently the material when presented as a theoretical discussion seems thin and to exclude too many obviously influential factors. The data from animal experimentation are much clearer and are obviously conclusive as to the relation between learning and future action. The data from conditioned reflex experiments go beyond simple learning of action patterns and indicate that patterns, interpreted as emotional, may be set up that persist as a part of that animal's attitude to life thereafter.

In psychiatry, this concept has been elaborated into the hypothesis that certain mental illnesses are caused wholly by experiences that have taken place earlier in the life of the individual concerned. This hypothesis is usually called upon to explain the occurrence of the neuroses and, by some, of certain psychotic types of illness. A special application of this is that mental illnesses may be precipitated by either external or internal stresses playing upon the person.

These concepts are widely accepted and highly regarded in the United States, but there are schools of psychiatry, to which many of our European and Asiatic colleagues belong, that do not accept them as proved and tend to deride their scientific value as a working hypothesis. This nonacceptance, among other things, should act as a goad to continuous research so that the hypothesis involved may be brought continuously closer to the realm of proved generalities among the laws of science.

Unlike the avenue of the prevention of organic disorders, where methods are clear and research problems relatively familiar, in the area of psychogenesis, methodology is not clear and theoretic problems are legion. There is no such statistically reliable correlation between neurosis, for example, and some syndrome of childhood experiences as there is between syphilis and the paresis that sometimes follows it, the paresis never existing without the pre-existing syphilis. Most of us are more convinced of the psychogenic basis for the neuroses. Talking about the problem of the "bridge" between prior experience and mental illness with Dr. John Whitehorn it was said the "bridge" seemed much easier to cross in the case of the neuroses, but that for schizophrenia it seemed an almost insurmountable problem. He made, in his calm but sometimes devastating way, the simple remark that perhaps it only seemed easier—that didn't mean that it really was. Nevertheless, psychiatrists in acknowledging the validity of

the psychogenic hypothesis accept the concept that there is a "bridge" of causation between early experience and later illness or other behavior disorder. This does not, of course, mean that we must also accept any particular theory of dynamic mechanism, or even any of the suspiciously direct concepts of personality type such as the oral and anal types, or the postulated relationship between paranoid states and homosexuality, latent or expressed. It is not necessary to concern ourselves with dynamics according to Freud, Jung, Adler, Meyer, or any other system. All that is needed is to accept as valid the simple statement that life experience not directly affecting the structure of the organism can influence later behavior and, in extreme cases, lead to symptoms identifiable as psychiatric illness of one sort or another.

Unless this concept is a true one, there is no basis for the prevention of the mental illness now thought to be partially or wholly psychogenic, and no basis for the hope that mental health can be promoted other than through protection against hereditary defect or organic injury. Unless it has validity, there is hardly a foundation for research in psychiatry other than in the basic sciences. If, however, the hypothesis of psychogenesis is true, then there logically follow responsibilities for preventive efforts that the psychiatrist cannot escape. These include responsibility for doing whatever is possible to interfere with the damaging action of experiences during development, either by prevention of the circumstances that lead to the experience, or by changing the impact of the experience on the personality so that it shall not be damaged. Not all psychiatrists accept this type of responsibility as a logical result of their beliefs. Some tend to escape the responsibility by arguing that all mental illnesses and behavior disorders are of multiple origin and that alteration of any one or a few factors will make little or no difference on the whole. This is as logical as not repairing a thread in the warp on a loom since there are so many others to support it, or, in the case of a surgeon, cutting blood vessels in a wanton manner because a collateral circulation exists. Others tend to avoid the responsibility implied by arguing that many experiences are dictated by inner forces and by fundamental instincts that cannot be altered. Much of this type of thinking is at variance with modern learning theory in animal and human psychology.

The stand taken here is that healthy personality development can be promoted, that the psychogenic mental illnesses are preventable, and that one day we shall be able to demonstrate this to be true by unassailable statistical data.

A thorough review of his writings reveals that Adolf Meyer did not take such a stand (1). Mental hygiene as he conceived it appears to have consisted of the diagnosing of weaknesses in the personality of an individual and then arranging his environment and, so far as possible, adjusting his conflicts so that he would not develop overt symptomatology. This conclusion was something of a surprise, for we had previously been certain that our position closely paralleled his. It is possible that this was the case but that his thinking in his later years had progressed beyond his published papers on mental hygiene, the last of which appeared in *Child Study,* 3 years before his retirement and 12 years before his death.

Freud appears to have given little if any attention to the application of his work for prevention. In Fodor and Gaynor's Dictionary (2) there is no reference to mental hygiene or prophylaxis, nor have I been able to find other references to this field in his writings.

In his recent Cooper Union address, "The Contribution of Freud to Mental Health," Hart (3) points out the many suggestions this leader made in psychopathology and in treatment, but there is very little on how the presumably inevitable stages of sexuality and the succession of sites of libidinous fixation should be handled in order to avoid the illnesses he studied. Freud stimulated interest in the effect of cultural concepts on the individual, but he made few if any suggestions, beyond rather vague ones about sex education, on which one might act to protect an individual from adverse cultural stresses or to change the patterns of a culture better to suit the human beings who live under its sometimes noxious stimuli. There is little in Freud's writings to indicate how the family can act to resolve the Oedipus complex in the promotion of the health of all children. While

his theories show why the Ten Commandments are necessary, there is little suggestion as to how man's personality might be so changed that these rules would need less enforcement. Indeed, in his *Civilization and Its Discontents,* a product of his matured thinking, he states that civilization can grow only by increasing repressions and consequent neurosis(4). Freud's major hypothesis is that, basically, the human being is ruled by instinct and by innately determined developmental patterns. He shows many ways in which these patterns can turn out diseased characters and ill people, but he says little about how any worker or group can step in to prevent the disasters he demonstrates so clearly.

Popular books on dynamic mechanisms seem to be written with prophylactic intent though usually they come at this by talking about disease and its presumed causal factors. It is rare that one finds an author whose approach is positive, who says "Do this." The usual pattern is rather to say, in effect, "See how badly this turned out?" or "It is, of course, obvious that this should not be done." Such books often seem to leave the whole process of finding out what is right to do to the synthesizing capacity of the reader, and confine themselves to pointing out what gives trouble in some cases. For the parent or teacher with "soul so dead" that he has not done more than one of these presumably etiologically important acts, one may feel so sorry that he may be led, as was Kanner, to write in defence of parents(5).

Most psychiatrists nowadays either boast of a knowledge of anthropology or apologize that they do not have it. What is such knowledge for? Surely it is not just to contribute to pathology, a dissecting of the threads of an illness to see how it came about. It must also have some value in a more constructive sense, to help explain the process of the construction of the personality as well as furnish a diagram of its present status. It must be to give hints, from comparing different developments in different cultures, so that something may be done to improve personalities in our own land. James Clark Moloney's *Battle for Mental Health*(6) is a valiant attempt to carry this out, though we do not agree with some of the concepts he promotes(7). Many of our colleagues are less frank about the eventual prophylactic intent of anthropological studies.

Aside from the broad cultural forms studied by the anthropologist, there is the field of sociology, community forces depending on more local situations within the broad culture, which are now being avidly studied by all of us. Many biographies of living persons and of the illustrious dead deal with such factors in the explanation of illnesses, but few deal with them as amenable to changes that would foster mental health in any direct way. For example, psychiatrists have had the temerity to point out the inverse relationship between the prevalence of juvenile delinquency and the number of playgrounds available in various areas of cities, though this has been the burden of the reports of the Juvenile Court Judge in Baltimore for many years(8). The psychiatrist seems to grant the importance of such a factor, after the breakdown of the personality, but to retreat from taking the logical step of establishing the playgrounds to prevent delinquency. We seem to recoil from transferring our stated beliefs about how antisocial or otherwise pathologic behavior came about into conclusions that the changeable factors ought to be changed. There is a sort of retreat here that is difficult to understand.

One might expect that the field of child guidance would have supplied many workers able, from their experience, to see in their patients patterns of forces that have led to certain outcomes sufficiently frequently that they might point out how the progression of events could be interfered with in some way. Perhaps through the press of daily work with sick children and their parents, they continue to see only the pathological progression and do not speculate enough on how it might be interfered with so that the same end might be avoided for others. In any case, it can be said that the child guidance movement has thus far contributed much less to an understanding of prevention than it has to treatment.

If such factors as parental rejection, lack of understanding of the child by the parent, jealousy of the parent of the same sex, and disgust with genital and excretory functions are important in psychogenesis of behavior

disorder, then adjustment of the attitudes underlying such factors must have prophylactic effect. It is surprising that so few psychiatrists feel that this prophylaxis is within their responsibility to the population at large.

Much of the impetus in the field of prevention has come from pediatrics and from psychology. Certainly Spock(9) has never doubted that health springs from the experiences through which a child passes, nor did Holt(10) before him, though their solutions of the problem are very different. Gesell recognized the "embryology of behavior" and turned to the detailed study of the normal child to clarify the results of the developmental process(11). Washburn and Sontag and their students have looked closely at the influences bearing on the child to see how they affected the resulting adult. The psychologists, perhaps particularly the educational psychologists, have given much attention to the problem. Animal psychologists such as Lidell(12), Scott(13), and Gantt (14) have attempted to reduce the theory of psychodynamics to the level of the controlled experiment and, along with demonstrating the difficulty of the task, have come up with very interesting findings concerning the mother-child relationship and the differing effect of experiences according to the developmental level at which they occur. The theory of "critical periods" in development, that there are certain periods when patterns must be developed if they are to be developed at all, is reasonably established for some functions. Its ramifications and refinements are still to be worked out, but the structure for future thinking is at hand. Psychiatrists have a tendency to look askance at much of this work on developmental patterns, contending that it is too simple to be applied to the human animal. It is perhaps wise to recall that Freud had one 5-hour course in psychiatry and that Meyer was a neuropathologist when each began his work.

It is probable that this apparent avoidance of clear statements of prophylactic responsibility finds its basis in other than logical, rational considerations. As psychiatrists, we seem afraid of the logical conclusions drawn from our own theories. We are afraid of the power of the Frankenstein we have created in public education and public expectancy. And well we should be, for we are dealing with very powerful forces for good or for ill. Seeley(15) has said:

> But as mental hygienists we have now added to ordinary self-consciousness a self-consciousness of a different kind: different in its accuracy; different in its penetration and depth; different in that it continuously tears away the veil of privacy from what was hitherto private; different in that we are ourselves self-consciously engaged in building it up; and different in that we know that our immediate associates and friends are so doing, and that they know we know. This is in some important sense a radically new way of life.

Somewhat abashed by the responsibility outlined, Seeley discussed the possibility of turning back. He concludes:

> But it is no longer even a question for policy. No known man or body of men now has the power to arrest the flow or alter the general direction of events, even if, on mental health grounds, that should be indicated. If we, the mental hygienists, should amputate our writing arms and seal our reluctant lips, the field would fall to the quack and the charlatan, and the principal difference would be that the self-consciousness would be worse-founded and more misleading. There is no choice open in that direction for us, any more than there is a way of abdication for the physicists in the face of the atomic bomb and its more violent variants.

What is there of reassurance to be found in this anxiety-producing situation, which may be paralyzing prophylactic action in some psychiatrists? Lemkau(16) has suggested 3 axes for advance: first, epidemiological studies; second, studies of development; and finally, studies in communication. There is not time to detail the data in all areas, but a rapid examination of a few segments will indicate clearly that there are points of attack justified by reasonably sound data.

The most telling material is that dealing with the arrest of emotional growth in the institutionalized infant who is understimulated. Bowlby's widely circulated book, *Maternal Care and Mental Health*(17), published by the World Health Organization, has so completely documented this field that it will not be further discussed here. If these data are granted as significant, much of the work of preparing families for the reception of infants takes on definite meaning as mental hygiene. Furthermore, it places on the psychiatrist a responsibility for helping his community maintain high standards of "maternal" care in its nursery schools, pediatric hos-

pitals, crèches, preadoption homes. The psychiatrist who believes in psychogenesis of mental illness will almost be driven to learn whether the licensing laws for such institutions in his community include the supervision of program, as well as of sanitation, and to stimulate cooperation with welfare, health, and educational authorities in maintaining acceptable standards.

Carney Landis(18) in his book on the psychosexual development of crippled women shows that arrest of development in this area and continuation of a childlike dependency regularly results in girls deprived of contacts because of invalidism; this merciful failure of development in these persons relieves them of strains that might otherwise be unbearable under their circumstances.

This is a helpful use of the principle of the critical-period concept. Full psychosexual development fails because of lack of stimulation. Like the use of lobotomy, the interference with the fundamental capacities of the individual must be approached with the greatest care, but the tool is nevertheless available.

Baldwin(19) has shown that children reared under differing home atmospheres have personalities that differ in a reasonably regular pattern. It has been shown that middle-class children with more "strict" upbringing produce more thumbsuckers and masturbators than children of lower class groups where more permissive methods are in vogue (20).

Where evidence of such differences prove actually to be related to the middle-class strivings, there is responsibility for the mental hygienist if he believes that masturbation and thumbsucking are symptoms that interfere with developmentally helpful parent-child relationships.

Cooper(21) has shown that in all probability the relief of friction between mother and child through increasing the mother's understanding of the child's activity decreases the amount of disturbing activity in later periods of development. Lippitt's acute experiments on the effect of differing types of leadership illustrate another field for the promotion of healthy personality function(22). There are many experiments in educational psychology that support this work. Clara Davis' work on children's eating habits furnishes an experimental base for many of our teachings about feeding problems in children (23).

There are other areas, where similar data exist, that seem to show relatively definite cause-and-effect relationships on which sufficient confidence can be placed as a basis for action in working toward the building of sound personality structure. Those cited are merely samples. It is also true, however, that many more important concepts we are tempted to teach do not have a sound basis in scientific data. Orlansky(24) and more recently Sewell(25) have pointed out how frail the evidence is for such concepts as the Oedipus complex, the importance of bowel training, the effect of different patterns of discipline. H. V. Davis(26) has indicated that the widely accepted concept of sucking need does not hold up in his carefully conducted experiments. There is no question of the need for an enormous amount of research that will give us more reassurance and allow us to act with greater security, but there are also ample data on which to base action now.

The conclusions now arrived at are two. First, and not very much elaborated, is that there is a mental hygiene at the simplest, organic level. Second, it has been shown that, if there are psychogenic illnesses, there rests upon mental hygienists and psychiatrists the responsibility to see how any part of known dynamic complexes can be altered for members of the population so that such illnesses will not result. There are reasonably sound experimental data on which we can act with confidence, but there remains much research to be done. The methods for such research are not now generally a part of the education for psychiatrists but, if we are to gain the respect of our colleagues in other fields of scientific endeavor, we shall have to learn the methods available and apply them more rigorously in our studies. The flashes of insight that have characterized the great leaders of our field in the past must be documented painstakingly with proof, a type of scientific discipline of which psychiatrists are perhaps more derogatory than appreciative.

We have done a great deal of work, too little of it well evaluated, on how the public shall be influenced. We can work further on this problem with our colleagues in health

education. There is a very real difference between the technical ability to deal with the concepts involved in the promotion of mental health and the technical ability to reach the public with the concepts or procedures. The function of the public health organization is to translate hygienic concepts of all kinds from the laboratories and consulting room, where they are evolved, into effective usage by populations. Public health administrators are trained to do this job. To help the 5,000 or 6,000 medical men engaged in this work in the United States there are more than 30,000 public health nurses, most of whom are in more or less intimate contact with the families in their communities. This organization and these people have the skills whereby our hygienic concepts may be put into effect.

There are many other helpers—teachers, ministers, and all the rest that are listed so frequently. But the principal responsibility for what these helpers promote and disseminate, for their education and for its content, lies with the psychiatrists and mental hygienists. In so far as we uphold the psychogenic theory of mental illness this is an inescapable responsibility. It is inescapable logically and, for many, inescapable ethically as well.

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PERSONNEL AWARENESS OF PATIENTS' SOCIALIZING CAPACITY [1]

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INTRODUCTION

Disturbed patients, perhaps because of their self-involvement and preoccupation, lack of interest or motivation, are often not receptive to new activities. Other things being equal, they are apt to respond more favorably to situations and activities that are familiar and therefore less threatening. Also, they seem to prefer a simple rather than a complex task.

In socializing patients, it is thus necessary for the nurse to select appropriate activities, *i.e.*, those that are simple, familiar, or those for which the patient has at some time had a strong desire. This requires that the nurse be aware of the activities in which her patient was interested before hospitalization. This knowledge may be a measure of her success in the sphere of socialization. It is our belief that pre-existing interests can be used as a foundation upon which a healthier use of former interests, or altogether new interests, can be built.

METHODOLOGY

Prehospitalization leisure-time pursuits of 30 patients as described by family members and by personnel were classified as follows: (1) skills, *i.e.*, pursuits that require ability or competence to perform, and (2) interests, *i.e.*, activities that one enjoys watching others perform, in which one would like to participate or which require mental rather than physical activity.

Skills and interests were categorized in terms of social relevancy and nonrelevancy. Classification is as follows:

A. *Socially relevant.*—Those skills and interests pursued in the presence of others where socialization is either the primary goal or where there is a possibility for socialization to take place, for example, (1) solitary activities—those in which opportunity for socialization is present but not necessarily taken, such as attending movies, visiting museums, etc. (2) Casual group activities—those where interaction is always present but where little or no planning effort is required, such as card-playing, informal entertaining, etc. (3) Structured group activities—those where considerable preplanning is necessary, such as committee work, reading groups, etc.

B. Socially nonrelevant.—Those skills and interests pursued alone for self-diversion, such as crafts, reading.

In order to identify skills and interests in terms of the specialized abilities they require, a second set of categories was set up: (1) Everyday or routine pursuits, chatting with friends, listening to radio, watching television, shopping; (2) Organized group activities, including sports such as tennis, ping-pong, and swimming; and also clubs and other group work such as bridge clubs, and working on committees; (3) Artistic activities such as practical or domestic arts including crafts, cookery, clothes designing, and active participation in aesthetic arts, *e.g.*, painting, ballet, singing, and passive or spectator participation in the aesthetic arts such as visiting museums and listening to music; and (4) Non-artistic cultural pursuits including lectures, current events, and scientific and philosophical reading.

These 2 sets of categories were applied to prehospitalization leisure-time pursuits of 30 female patients who were on the acute ward during a two-week period. Diagnoses included schizophrenia, manic-depressive psychosis, agitated depression, involutional melancholia and post-partum psychosis. Family members of these patients were interviewed by the social worker, who used a form, "Inventory of Social Skills and Interests," prepared by the writer as a guide for gaining information on patients' prehospitalization leisure-time pursuits (see appendix).

[1] This study was made possible through a grant-in-aid of research by the American Nurses' Association to the Boston Psychopathic Hospital.

[2] We acknowledge with gratitude the assistance of Thelma Baker, B.A., consultant in statistical analysis, Boston Psychopathic Hospital, and Nancy Ogilby, M.S.S., social worker, Boston Psychopathic Hospital. Harriet Kandler, R.N. offered valuable suggestions and criticisms in the preparation of this manuscript.

The interview was also employed by the writer to gain information on personnel's awareness of patient's prehospitalization interests and skills. Seventeen nurses—(3 graduate nurses, 6 affiliating students, and 8 attendant nurses)—assigned for at least 2 weeks to the female acute ward, were interviewed. Their 2-week assignment coincided with the 2 weeks during which the patients studied were on this ward. Each of the nurses was handed a list of patients who were on the ward during the 2-week period prior to time of interview. They were asked if any patients on this list had prehospitalization skills and interests similar to or different from theirs; what were these skills and interests; what were the prehospitalization skills and interests of patients they failed to mention upon first questioning, and how they learned about these pre-illness activities. These questions were selected for the following reasons: (1) to prompt more spontaneous responses than would be possible with direct questioning about each patient, (2) to make the interview more interesting for personnel, and (3) to elicit information concerning personnel's attitudes and approaches to patients and their families.

Differences between the reports of family members and personnel were analyzed by the use of 3 statistical measures: (1) a percentage-of-agreement test using the formula:

$$\frac{\text{Full Agreement} + \frac{1}{2}\ \text{Partial Agreement}}{\text{N}}$$

Full Agreement = 50%
Partial Agreement = 10–50%
Disagreement = 0–10%

to denote the extent percentagewise of personnel's knowledge of patients' prehospitalization leisure-time pursuits; (2) a test of significance of proportionate differences in types of pursuits as reported by both groups; and (3) a test of significance using means and standard deviations to show differences in the gross numbers of pursuits reported by family members and by personnel. The latter test was employed as a check on the percentage-of-agreement test.

DESCRIPTION OF PATIENTS' LEISURE-TIME PURSUITS AS OBTAINED FROM FAMILY MEMBERS

According to their families this group of patients possessed before hospitalization an average of 9.5 leisure-time pursuits. They were reported to have had significantly more skills than interests (significant at $>.001$ level). Since skills denote activity and interests are generally passive, this finding would imply that when well these patients were doers rather than spectators. One explanation for this greater number of skills may be that many of these patients were housewives possessing a number of skills more or less related to homemaking, and a fairly large number were younger patients skilled in sports, dancing, committee work, etc.

The most favored skills were casual group activities, such as dancing, card-playing, informal entertaining, and unstructured sports. Although structured group skills were less popular, participation in organized sports and in committee work were mentioned sufficiently frequently to be worthy of note. With interests, on the other hand, socially relevant, solitary activities such as attending movies and watching television were the most popular.

Most mentioned among the socially nonrelevant skills were crafts and homemaking; among the socially nonrelevant interests were listening to music and reading (Table 1).

Although the above-specified activities offered the most interest for this group, a few had a broader variety of pursuits. At least one of these patients painted, designed clothing, engaged in choral work, was proficient in the clerical arts, entered her arts and crafts into exhibits, was interested in travel, did professional writing, or engaged in ballet as a career.

Analysis of patients' leisure-time pursuits in terms of the descriptive categories revealed 3 predominant types of interests, each significantly higher than the preceding. Most popular were everyday or routine pursuits such as homemaking, attending movies, watching television (39% of all pursuits). Next were clubs and other organized group activities (26% of all pursuits). Third in popularity were practical and domestic arts (13% of all pursuits). The remaining 4 types—sports, aesthetic arts (active and passive), and nonartistic cultural activities—all offered a similar degree of interest, a degree

significantly lower than that for the first 3 types of pursuits.

DESCRIPTION OF PATIENTS' LEISURE-TIME PURSUITS AS OBTAINED FROM PERSONNEL

Observation of and communication with patients were personnel's 2 main sources of information concerning prehospitalization leisure-time pursuits. Sources less frequently used were other ward personnel, personnel from other disciplines, such as occupational therapy and social work, and patients' families. In only a few instances was there evidence that information was obtained from personnel or family sources previous to verbalization or demonstration of their skills and interests by the patients themselves.

Evidence of lack of communication with relatives and with personnel about patients' social interests and skills is seen in the comparatively small number (78) of leisure-time pursuits reported by personnel for this group. The distribution of these pursuits was as follows: (1) significantly more skills than interests (significant at the .001 level); (2) significantly more socially relevant skills in the structured category than in either the casual or solitary categories (significant at the .02 level); and (3) significantly more socially nonrelevant than socially relevant skills and interests (significant at the .02 level) (Table 1).

TABLE 1

PATIENTS' SOCIALLY RELEVANT AND NONRELEVANT PREHOSPITALIZATION LEISURE-TIME PURSUITS AS REPORTED BY FAMILY MEMBERS AND PERSONNEL

Reported by family members	Soc. relevant			Soc. nonrelevant	Totals
	Sol.	Casual	Str.		
Skills	7	54	30	88	179
Interests	43	2	7	54	106
All Pursuits..	50	56	37	142	285
Reported by personnel					
Skills	3	6	13	27	49
Interests	4	3	3	19	29
All Pursuits..	7	9	16	46	78

Key:
Sol. = Solitary
Str. = Structured
Soc. = Socially

According to personnel, patients' favored prehospitalization leisure-time pursuits were practical and domestic arts, mainly sewing, crocheting, knitting and cooking, and club and other group activities, mainly committee work and planned entertaining. Everyday pursuits, sports, aesthetic arts (active and passive), and nonartistic cultural pursuits were felt by personnel to have been decidedly less favored (significant difference at $>.01$ level) by patients before they were hospitalized.

PERSONNEL'S AWARENESS OF PATIENTS' PREHOSPITALIZATION LEISURE-TIME PURSUITS

There were 4 outstanding differences between the reports of personnel and those of patients' families: (1) personnel saw patients as having significantly fewer leisure-time pursuits than did patients' families (78 as compared with 285); (2) personnel reported patients' prehospitalization leisure-time pursuits as being primarily socially nonrelevant whereas family members felt they were primarily socially relevant; (3) personnel saw patients' socially relevant skills as chiefly of the structured variety whereas family members saw these as chiefly casual and unstructured; and (4) personnel saw practical and domestic arts and club and other group activities as most popular whereas the families listed everyday or routine pursuits as most favored.

In minimizing the quantity and social relevancy of patients' pre-illness leisure-time activities, personnel revealed a tendency to judge patients' past capacity for socializing in the light of their lowered capacity while on the acute ward. They tended also to estimate favored prehospitalization pastimes in the light of observable ward activities these patients pursued. Both these tendencies point to lack of knowledge on the part of personnel of prehospitalization socializing of their patients.

A patient-by-patient analysis revealed personnel's lack of knowledge in terms of percentage of agreement. For the total group there was 23.3% agreement between personnel and patients' families as to specific interests and skills. There was full agreement on 3 patients, partial agreement on 8 patients, and disagreement on the remaining 19. Highest percentage of agreement (30-66%) was on patients who were outgoing,

talkative, and either normally active or somewhat overactive. Lowest agreement (0%) occurred in 10 cases for whom no skills or interests were mentioned by personnel; these were patients who were considerably withdrawn and who showed little or no interest in ward and hospital activities.

In some instances, personnel included as interests certain topics such as religion, which were part of the patient's delusional system; in other instances, personnel mentioned newly developed interests not mentioned by patients' families.

Four of the 17 personnel were unable to mention any prehospitalization interests of patients. Two of these, affiliating students of nursing, expressed the feeling that they had *something* in common with several of the patients. The third, an attendant, merely said she did not know. The fourth, another attendant, explained: "Reading the records is the only way to find out about patients' interests before they were sick. I don't read the records because there are some things I'd rather not know about patients."

The remaining 13 personnel knew at least one but no more than 4 skills or interests of varying numbers of patients, the range being one to 11 patients. This may be compared with an average, as given by relatives, of 9.5 skills and/or interests. Greatest awareness of patients' skills was shown by 2 graduate nurses. In spite of her high degree of awareness, one of these nurses did not know that one of her patients had professional and artistic interest in ballet, even though ballet was the nurse's own foremost interest at the time. In conversing with the patient, she had learned of only one of her other interests. Closer contact with this patient's family would have revealed their mutual interest and would have furnished the nurse with another basis for socializing this quiet and somewhat withdrawn patient.

In general, personnel were most aware of those prehospitalization skills and interests that the patients had already begun to pursue again during their hospitalization. To what extent ward personnel were instrumental in patients' relearning these skills cannot be measured by the data of this study. It would seem, however, that since patients with whose skills personnel were least familiar were those who had not as yet begun to socialize, personnel may not be functioning as effectively as they might be in the initial phases of socializing patients. Also, it may be that personnel expect the occupational therapy department to play the greater role in this relearning process.

Two important questions herein may be discussed: (1) how to increase personnel awareness of patients' socializing capacity; and (2) how to increase patients' use of this socializing ability.

Concerning both these questions, the major difficulty in the Boston Psychopathic Hospital setting seems to be the lack of communication between occupational therapist and nurse, between social worker who obtains information on admission and nurse, and between patient's family and nurse. This deficiency in communication is in part due to the lack of recognition of socializing leadership as an important function of nursing.

Clearer definition of the nurse's role and education of personnel for socializing leadership are a first step in remedying the present situation. Use of a more standardized technique for obtaining and transmitting initial information on patients' pre-illness socializing may serve as one means of improving coordination between the departments concerned. Finally, reports such as this serve to focus interest on the problem by pointing out the deficit which exists between the patient's capacity and the nurse's knowledge thereof.

Summary

Interviews of ward personnel and families of patients were conducted to determine the quantity and quality of patients' leisure-time pursuits; to determine the degree of personnel's awareness of these pursuits; and to determine the sources utilized by personnel for gaining information on the leisure-time activities prior to hospitalization. The findings were as follows:

1. Before illness, patients primarily selected leisure-time activities that required skill rather than passive watching. Most popular were activities of a routine, everyday nature pursued casually in groups. A few patients had more specialized skills and

interests such as ballet, clothes designing, etc.

2. Personnel were aware of only 23.3% of patients' pre-illness leisure-time activities. There was high awareness on 3 patients, partial awareness on 8, and no awareness on 19. Although they were in agreement with family members as to patients' being doers rather than spectators (more active than passive pursuits), personnel saw patients as pursuing their leisure-time activities alone rather than in groups. They showed their highest awareness in the case of patients who had already begun to socialize.

3. Two main sources for gaining information regarding patients' prehospitalization activities were conversation with and observation of the patients on the ward. In only a few instances did they communicate with other personnel or with patients' families before the patients themselves made their interests known.

These findings have special relevance to the nurse's role as a socializing influence. It is clear that nurses are very often unaware of the socializing capacities of their patients. Without this information, the possibilities of bringing patients into social interaction remain limited, and many opportunities to help them emerge from their withdrawn state are missed. On the other hand, if fully informed of the patients' potentialities, the nurse may carry out more effectively her important function as a socializing leader.

APPENDIX

Inventory of Social Skills and Interests

Name: Jane Doe
Age: 35 Date Adm. 9-16-51
Occupation: Housewife

	Interest		Skill	Specific		How Manifested?
Activities	Much	Some		Interest	Skill	
Crafts		x	x	tatting	knitting	for children and husband
Domestic Arts			x		cookery	cooks foreign dishes
Clerical Arts						
Games		x	x	cards	cards	played weekly; wants to learn bridge
Sports						
Parties						
Entertaining			x		informal	friends visited frequently
Club Memberships	x			church		belonged to 3 groups
Committee Work			x		secretary	for 2 organizations
Current Events		x		newspaper		read and discussed news
Nature Study						
Reading						
Writing						
Music						
Paint, Draw, Sculp.						
Drama						
Dance						
Movies	x					attended weekly
Television						

Likes to Discuss Which of Above: *Cookery, club activities, movies in particular.*

Comments: Was always thought of as a good conversationalist until about eight months ago when illness began.

PSYCHOTHERAPY OF SCHIZOPHRENIA IN AN OUTPATIENT SETTING[1]

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The Briggs Clinic is the outpatient department of the Boston State Hospital, and has been in operation since February, 1950. In setting up the clinic, certain policies were formulated with the aim of offering treatment to all categories of mental illness. It was felt that neither the diagnosis of psychosis nor the degree of psychosis should be considered as barriers to outpatient treatment. It was our feeling that the experience gained in psychotherapy of schizophrenics within the hospital should have application outside the hospital and that it should be possible to save some patients from hospitalization. Apart from the gains that could accrue to the patient, we were aware that keeping as few as 20 patients out of the hospital for one year would, in itself, pay the cost of our annual clinic budget. We were particularly interested in treating those patients who had never been hospitalized or who had been discharged from trial visit from an institution.

As far as we know, no particular number of psychotics was sent to us because of our known but unpublicized interest in such patients. Yet, it is of importance to report that approximately 20% of our intake has carried a diagnosis of psychosis, almost all schizophrenia. This number includes patients whom we referred for immediate hospitalization and patients who never returned after the initial visit. There were certain patients for whom we felt outpatient treatment was inadvisable. These fell into the following 4 categories.

(1) Patients so acutely disturbed as to be immediately dangerous to themselves and/or others. There were only 2 such cases. This small number resulted only from a very liberal interpretation as to what constituted danger for the patient or others. The influence of a helpful clinic situation on the active schizophrenic should not be minimized. The danger that might be present was assessed with the kind of relationship the patient showed in the intake process which at this clinic consists of an interview with a social worker or psychologist followed immediately by a further evaluation by the clinic director. In some cases, the word of the patient that he would control himself was accepted. To date, there has been no cause for grief.

(2) An occasional, known chronic patient with many hospitalizations whose desire for a dependent hospital status overrode all his other wishes. These, too, were very few and we agreed with the patient only in one instance wherein he had no home, no relatives, and was incapable of taking care of himself. In one other case, a woman begged for months to be hospitalized, but we refused as she did not need hospital care. Eventually, she gave up in despair and broke treatment—but did not return to the hospital.

(3) An occasional patient whose family forced hospitalization by refusing to cooperate with the clinic (*i.e.*, refusing to bring a patient for his visits) or by refusing to accept any responsibility for the patient.

(4) The aged psychotic with organic changes was refused treatment only because we did not wish to encourage the influx of these patients.

Hospitalization as a solution for the schizophrenic should not be considered lightly. In many cases, it can produce subtle but irreparable damage to that part of the patient that is least visible—his self-respect. From our experience hospitalization may have different meanings to different patients. In general, the doctor proposes hospitalization in good faith and with only benefit for the patient in view. We have learned more clearly what it may mean to the patient. Case examples may illustrate these points.

A man in his 30's had come alone to Boston several days previously from another city in Massachusetts. He had actually fled his home in a state of acute disturbance. He took a room in a hotel and there sat suffering auditory hallucinations and tre-

[1] Read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

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mendous fear. After several potentially serious suicidal attempts, he walked to a general hospital and was referred to the clinic. A diagnosis of an acute schizophrenic reaction was made. The patient was struggling violently for control and begged for protection from himself. That he could make this request in the face of an acute turmoil was sufficient to indicate his request should be granted. He was promptly hospitalized and recovered rapidly. His most urgent need was for refuge in a protective environment where external control was assured. Under such circumstances, he could quickly mobilize his own resources to restore his health.

Another patient, a young man, entered the clinic in an acute homosexual panic. He was blocked and almost catatonic. He was able to best make his needs known when hospitalization was suggested. His terror mounted at the proposal and he began to plead for clinic treatment. He revealed that he had been a patient in the closed section of a veterans' hospital in another state. It became clear then that what he was trying to say was that he could not stand being locked in a ward *with other men*. He was told that if he promised to return to us the next day, we would drop the idea of hospitalization. He returned the next day, entered active psychotherapy, and eventually was discharged from treatment. Here, a specific fear of the hospital was intimately related to the most pressing of the patient's conflicts. Recognition of this and yielding to the patient's wishes were probably as important as anything else in the treatment.

A female of 35 with a diagnosis of paranoid schizophrenia expressed her fear of hospitalization from the start. For her it meant final defeat. It is this sense of final defeat that should be the most important consideration before sending a patient to the hospital. In every psychotic patient there remains some degree of contact with reality. This is always particularly evident in the paranoid. The patient's struggle to control the terrifying impulses and the terrifying sensations experienced as emanating from the external environment seems never to cease. Hospitalization can mean that the struggle has ended in defeat for the patient and this defeat may be experienced as the final blow to all impulses struggling toward health. Thus, it happens so often that the hospitalized paranoid patient expresses his bitterness toward all those who put him in the hospital and all those who keep him there. It is our impression that a good portion of this bitterness is related to the sense of defeat, that is, his desire for health has been pessimistically destroyed by external forces. Such an impression is strengthened by the observation that, in the clinic treatment of seriously deluded patients with many ideas of reference, this special kind of bitterness is seldom noted and tends to disappear as soon as the patient feels secure in his new relationship as well as assured through experience that his freedom is not at stake.

In some, hospitalization means defeat in that the patient may now yield to destructive impulses against which he has more or less successfully defended himself outside the hospital. Although we have had to deal with intensely hostile patients, we have not yet had any outbursts of violence. Some of our neurotic patients have been noisier than our sickest psychotics.

Other meanings of hospitalization to the patient are more commonly heard in all settings. Thus, there is the fear of never being released from the hospital, which usually has the more personal meaning of final abandonment by the family. There are fears of beatings and mistreatment and, to so many patients, confinement to the hospital is punishment for unconsciously committed or wished-for crimes, and the hospital is a prison in the literal sense—thus, the frequent cry of the ward patient, "What crime did I commit to be put here?"

Lastly, in view of the meanings of hospitalization related above, there is the salutary influence of clinic treatment as a stimulant to the patient's self-respect. Although his conflicts are infantile, clinic treatments pay tribute to his independent adult strivings. He usually responds with the wish to exercise more control over himself and, most often, does so. One might say that clinic treatment places the patient on his own but at the same time within earshot of help. For some patients, their clinic contact is the only one in their lives in which they feel free of any kind of malignant control as exercised by the family, usually by the mother.

We cannot of course treat in a clinic the psychotic patient who is already violent and destructive before treatment, nor could we treat the overactive manic patient who is engaged in ceaseless activity.

This study includes 71 cases, 40 females and 31 males. Of these, 7 were called borderline since in each there was a predominance of psychotic defenses although symp-

tomatically each seemed to be operating neurotically. Fifty-seven carried diagnoses of schizophrenia of all categories, excluding the hebephrenic and simple types. There were 2 manic-depressives and 5 involutional psychoses. Cases other than schizophrenic have been included in this paper because our psychotherapeutic approach applies to any patient diagnosed psychotic. The 7 borderline cases all exhibited reactions of the schizophrenic type. During treatment, 26 patients were lost either by breaking off treatment completely or by being hospitalized, often at the insistence of relatives and without the knowledge of the clinic; this occurred in 9 of the 26 cases. Twelve have been discharged from treatment as improved; 23 are still in treatment and considered improved; 6 are still in treatment and considered unimproved; while 4 are new cases (in treatment for less than 2 months). In each case, the diagnosis was made by the director of the clinic.

Treatment of these patients has been confined to individual and group psychotherapy. Some patients have had both, but the majority were treated individually. A small number have been in group therapy only. All members of the clinic staff are engaged in the psychotherapy of psychotics under the supervision of the clinic director. The major part of the work is being done by the full-time personnel consisting of social workers and psychologist. A few cases have been treated by social work and psychology students. In 5 cases, both the patient and his immediate relative were treated. It has been our strong impression that in every case, distinct advantages would be gained if the patient and nearest relative could be in treatment at the same time. The pressure of our case-load has operated against us in this regard.

As might be expected, the most difficult phase of outpatient treatment of the psychotic lies in relieving the patient of his fears quickly enough to keep him in treatment. We regard these fears as having always been present but now accentuated by the fact that we are, in effect, asking the patient to engage in a relationship with us. The distress, the need for psychotic defenses, and the need for flight expressed in withdrawal are derived from early painful relationships and are repeated in each setting where an interpersonal relationship, or the possibility of one, is present. Basically, the fears of the patient center about destructive fantasies in which both patient and therapist are threatened by destruction, so far as the patient is concerned. Whatever means we can employ to lessen these fears will serve to keep the patient in treatment, promote the growth of a positive transference, and eventually release anxiety of a more constructive, less overwhelming nature. There can be no set rules for the therapist to follow but rather we employ general principles within the framework of which each therapist may function in the light of his own personality. The therapist, therefore, attempts to resolve some of the patient's fears by carefully investigating the nature of his verbal and nonverbal responses. Concurrently, an attempt is made to provide a clinic atmosphere of acceptance and respect for the adult strivings of the patient. For example, where the patient is accompanied by his relative, we refuse to do with the relative that business that properly concerns the patient, such as collection of fees or making arrangements for future interviews. In all cases we attempt to set modest goals for ourselves although, as so often happens, these goals are not considered so modest by the patient. The 3 general goals we strive for are the creation of a positive relationship, the diminution of psychotic means of relating to people, and the use, by the patient, of those activities that are necessary for adult gratification, that is, productive employment, school, or a housewife-mother role. Each goal is interdependent and it is unlikely that one can be achieved without involving the other two.

It may be helpful to consider each of these goals in greater detail. The *sine qua non* of psychotherapy lies in the positive transference of the patient to the therapist. This is equally true in treating schizophrenics. In contrast to a hospital where confinement of the patient permits one to work with long patience toward this end, the speed with which this can be done is critical in a clinic since, as already noted, it is very difficult to keep the patient in treatment while escape through failure to keep appointments is so

readily available. We meet this problem by paying special attention to the manner in which the patient presents himself. We seek to understand his presenting attitude as being only an expression, in more or less disguised form, of conflictual feelings. These feelings motivate the particular kind of attitude, and that attitude must be one designed primarily to express discontent. At the same time, the patient's presenting attitude indicates his chief means of relating himself to people on the operational, everyday level and it permits him to remain quite unaware of the feelings that force him to act as he does. Immediate investigation of the patient's presenting attitude, be it one that manifests fear, anger, hopelessness, suspicion, or whatever, can serve to bring into the open the despairing feelings with which he is struggling. Thus, once the patient is deprived of that mechanism he most commonly and overtly employs to alienate those who may really be against him as well as those who seek to help him, he is then confronted with a new experience. It is new in the sense that he has been given the opportunity to find himself accepted as he is but understood as someone struggling with deeper, painful feelings so often perceived as being beyond his control. In this setting, a positive transference may develop very rapidly. This does not imply, of course, that nothing but smooth sailing is ahead. At this stage we are less concerned with what the patient says and more with how he is conducting himself with us. Minor bits of behavior may have more significance than the most elaborate details of life history. Facial expression, tone of voice, and vasomotor phenomena are commented on, questioned or wondered about, and efforts are made to correlate such observations with the patient's attitude toward the therapist.

A 21-year-old male presented himself with an attitude of suspicion, a facial expression that was partly troubled, and partly sullen, and a blanket denial that anything troubled him. The investigation of this mixed attitude resolved his ambivalence with regard to treatment by the end of the third interview and brought a distinct change in content. Previously, he spoke only of what he was unable to do, *i.e.*, unable to eat well, drink, go with girls, or make friends. Then the feelings motivating his presenting attitude appeared as this attitude was brought to the patient's awareness. These feelings were all destructive with enormous and varied fantasies of murduring people. He could reveal these impulses and why he felt so only as the positive relationship was stimulated by this kind of treatment. Prior to treatment, the most striking feature on the Rorschach was the intensity of his hostile urges. The whole test was permeated with blood, swords, and killings. In the special therapeutic relationship, the fear that he would lose control of his impulses subsided and he could talk about them.

A 29-year-old male, schizophrenic since the age of 13, and given up as hopeless 4 years earlier, revealed a chief attitude of suspicion and fear. He looked as though he expected to be struck or hunted down at any moment. His intake and diagnostic interviews were wholly nonverbal. Constant attempts to investigate and clarify his fearful attitude brought about a verbally expressed willingness to talk and to return to talk some more. In difficult moments he still communicates his feelings to his therapist with childlike drawings which then serve as a basis for discussion of his attitude to the therapist. Never without supervision for over 10 years, he has recently been coming to the clinic alone and feeling tremendously independent in doing so. His chief struggle is still with his feelings about the therapist.

Stated briefly, our rationale of treatment is that work should first center around the way and manner in which the patient seems to act and feel toward the therapist. The conduct of this investigation in a setting of warm, sincere acceptance may relieve the overwhelming tensions already present and so serve to make possible a positive relationship. The process may need repetition many times. Once the patient feels secure in his new relationship, the work begins of searching out the nature of his conflicts with the earlier and later figures in his life. An attempt is made to show the patient the similarity between his conflicts outside the clinic and those inside the clinic with his therapist. As he learns to tolerate and find ways of handling his feelings toward the therapist, he can extend these gains outside the clinic.

The second goal, the lessening of psychotic means of relating to people, cannot be separated from the first. The more successful the relationship with the therapist, the more realistic are his relationships with all people. In all cases, however, one can find continuing psychotic defenses. Usually, these defenses are not overt and may be employed only under stress.

The third goal, engaging in acceptable means of gratification, is apt to be very difficult and, for the most part, seems related to

the intensity of the desire to maintain a hostile dependent status. Getting the patient to do something constructive for himself can be more troublesome, and certainly more frustrating, than relieving him of a large part of his psychosis. The resistance against taking successful measures toward independence must be understood as resistance and is based, therefore, on reasons that are logical to the patient. Usually, these reasons are not only self-defeating for the patient, but also tend to keep in a constant state of provocation those figures in his immediate environment. For example, one young man who was relieved of his paranoid fears, nevertheless preferred to stay in bed at home during the day, thus forcing his parents to support him. At night he would go out and enjoy an active social life. In treatment, the therapist searches carefully for those defenses which the patient is employing to avoid assuming adult responsibilities. Analysis of the patient's current life situations will reveal emotional reactions already familiar in previous patient-therapist interactions. Usually, these emotional reactions are motivated by feelings of bitterness, the wish for revenge, and the narcissistic conviction that the patient has a right to exist parasitically to make up for the years of relationship experienced primarily as years of deprivation.

A 21-year-old male student entered this phase of treatment by making each interview a series of direct questions as to what he should do to study better, how to make friends, what his future goals should be, and many more of a similar nature. This persistent desire to be told what to do was understood in 2 ways: first, that he was very likely doing the same thing outside the clinic and, second, that by refusing to act upon the well-intentioned advice he was receiving outside, he could keep his advisers, *i.e.*, parents and teachers, in a constant state of irritation. In the process, of course, he would fail to do those things which were important to him alone. His reaction to advice from teachers would be to do even worse work; his reaction to advice from his parents would be to make himself even more helpless insofar as adult means of organizing his life were concerned. In treatment, these motives were exposed by refusing to answer his questions and forcing him to face up to the feelings behind them. Repeatedly, his current life situations were scrutinized in this light, verified in relationship to the therapist, and related to life experiences of the distant past. Eventually, there came the realization, through experience, that he was acting out in all his current relationships, old conflicts. The critical finding, for the patient, is the fact that the therapist remains a source of affection and help in spite of the patient's efforts to reduce him to the position of the ever-present enemy. This patient often threatened the therapist quite directly that if answers were not forthcoming, he would deliberately fail in his school work.

Other patients will get jobs quite readily only to return to the next interview already unemployed. Careful investigation of the circumstances surrounding loss of the job regularly reveals the kind of self-defeating, alienating reactions of the patient when confronted with the possibility of making real adult progress in life. The schizophrenic has ready for constant use a wide array of irritating attitudes which force the outside world to react against him and so keep him in an infantile state. These attitudes may be so subtle as to make it seem that the patient is always the victim of one series of misfortunes after another. He seeks to preserve this kind of self-deception. The task of the therapist is to expose it in the confines of the now secure treatment situation and to clarify it in all its manifestations as it affects patient-therapist, patient-current world, and patient-past world.

Another method of facilitating growth is to employ a manipulative technique in addition to that already mentioned. The patient may be referred to a social service agency with the aim of not only helping him to get a job, for instance, but also forcing him into a relationship with a new person in another setting who understands the problems of the psychotic. Ideally, therapist and case worker should confer and share ideas with regard to a plan of action.

No matter which method is employed, it is wise to accept the fact that one cannot think, in ordinary terms, of terminating connection with the psychotic who has recovered. It seems essential that the therapist regard himself as a filling station to which the patient must come at certain intervals for replenishment. The vast emptiness that the schizophrenic feels is relieved in successful treatment but rapidly returns when he invests some of his own interest and energy in people apart from the therapist. The therapist should make himself available to the patient at longer and longer intervals for an indefinite period. If the patient is to leave

the vicinity, communication by mail should be offered. In this stage of treatment, there is usually no need for special therapeutic activity on the part of the therapist. The patient finds tremendous comfort, relief, and strength, simply in seeing the therapist and reporting his activities since his last visit. The patient draws from the springs of warmth and the capacity of the therapist to give of his own affective life. The therapist may have the experience of seeing the withered patient bloom once more before his eyes. The repetition of this experience with many patients may drain the therapist dry and in this lies one of the reasons why psychotherapy of psychotic patients appears so unattractive to so many people.

In conclusion, we feel that there are tremendous opportunities for helping the psychotic patient outside hospital walls. It is likely that many are hospitalized who could be treated in a clinic. Our experience gives further validation to the recent experiments and interest in the role of a day-hospital wherein the patient returns to his usual life setting at the end of each afternoon.

PSYCHIATRIC PROBLEMS IN ELDERLY RESIDENTS OF COUNTY HOMES [1]

Report and Evaluation of a Survey Conducted in County Homes in Iowa

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County homes in Iowa were formerly known as county farms or poor farms. They house persons who constitute a problem for the community. The overwhelming majority of the residents are the so-called "poor," those who cannot support themselves and have no relatives who are liable or able to take care of them. The "poor" residents in turn can be classified into the following groups: (1) those who have financial problems only; (2) those who have, in addition, medical problems: to this group belong the chronically ill and physically handicapped but mentally healthy; (3) those who were admitted as alcoholics; and (4) the psychotics. Most of the latter group were either transferred from state hospitals or taken to the county homes directly by relatives on advice of the family doctor without medical consultation. A few psychotic patients are still committed as such directly to the county home by the county insanity commission.

As can be easily recognized, county homes are the outgrowths of workhouses or poorhouses in which the sick and healthy, the psychotic and nonpsychotic, the young and old have been indiscriminately housed together. The county homes are under the jurisdiction of the county authorities, although in Iowa the State Department of Health and the Board of Control of State Institutions have some limited rights of supervision.

Of 99 counties in the State of Iowa, 91 have county homes. Altogether there are slightly more than 4,200 residents of all age groups. About 2,100,[4] or approximately 50%, are 65 years of age or older. The gerontological unit of the Mental Health Institute in Cherokee conducted a survey of elderly residents in 4 county homes in Woodbury, Webster, Sioux, and O'Brien counties; these had a total of 226 residents of various age groups. Among them 126, or 55%, were found to be 65 years and over. These 126 residents were seen and interviewed by a team composed of a social worker, a ward therapist, and one of the authors (R. G.). This group was working in close contact with a fourth member of the unit and co-author of this paper (W. C. B.).

Methods and Technique

The method used in this survey was that of a questionnaire supplemented by interviews; the following aspects were covered: general information, mental and physical health, background, and personal attitudes and activities. This paper will discuss only the psychiatric part of the survey.

The residents were questioned, whenever possible, separately and privately. From 1¼ to 2 hours were used for each interview. Where satisfactory contact was possible, with the more normal residents, the questioning was more detailed. With psychotic residents the interviewer had to rely on less formal talks.

Psychotic subjects were usually interviewed by 2 members of the team, one of them a psychiatrist. In cases where answers could not be obtained from the subjects, the steward, his wife—the matron, or, in one case, the registered nurse, was called in and his or her information concerning the residents was recorded.

Information, particularly data concerning birth, length of stay in the county home, etc.,

[1] Read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

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[4] Information regarding the number of elderly residents in county homes in Iowa is based on inquiries to county welfare directors made in 1952 by the Gerontological Unit, Mental Health Institute in Cherokee.

was checked with the county home authorities. When the subject had been a patient at the state hospital his hospital records were studied and the data compared.

No attempt was made to establish a detailed psychiatric diagnosis. The task of the unit was limited to determining whether or not the patient was psychotic. For this purpose 2 large groups of symptoms were used. The first group included hallucinations, delusions, confusion, disturbance of orientation, memory impairment, and whether contact with the patient was possible. To symptoms of this group ratings were given, each of the symptoms being rated as 1. "Partly" or "?" answers were rated as ½. Subjects with zero to ½ scores were placed, in the preliminary classification, in the normal group; individuals with scores from ½ to 1½ were included, at first, in the mildly mentally ill group; those with scores of 2 and more were classified as psychotic. The final classification depended, in addition to the above scores, on 4 other criteria, the second group of symptoms: impairment of intelligence, of judgment, of adaptability to everyday routine, and whether or not the subject had a record of having been a patient in a mental hospital.

TABLE 1

CLASSIFICATION ACCORDING TO MENTAL STATUS OF RESIDENTS 65 YEARS AND OVER IN 4 COUNTY HOMES IN IOWA

County	Normal	Mildly mentally ill	Psychotic	Unclassified	Under 65 *	Total
O'Brien	6	5	3	..	..	14
Sioux	..	3	5	..	..	8
Webster ...	20	7	24	1	3 *	55
Woodbury ..	21	8	19	4	1 *	53
Total	47	23	51	5	4 *	130
%	36.15	17.69	39.23	3.85	3.08*	100.0

* These cases interviewed later proved to be under 65, and are therefore not included in subsequent tabulations.

Of the 130 residents interviewed, 5 remained unclassified because no understanding was possible with them and no reliable information could be secured from other sources. Four other subjects, found to be younger than 65, were excluded. The rest, all 65 years of age and over, were distributed, as can be seen in Table 1, in 3 groups: normal, 47 (36%), mildly mentally ill, 23 (18%), and psychotic, 51 (39%). Residents with whom an interview was possible on a nonpsychotic level and who did not have psychiatric hospital records were considered mentally normal. The only exception was made for alcoholics with hospital records who were, however, diagnosed as nonpsychotic. The mentally normal group also included elderly subjects with mild memory defects and the mental defective who made an excellent county home adjustment. However, those with zero scores in the preliminary classification, that is, subjects with whom an interview was possible on a nonpsychotic level and who made a more or less satisfactory adjustment to the daily routine, but who had mental hospital records or psychotic episodes, were placed in the mildly mentally ill group. One case with hallucinations was included in the same classification because of the excellent social adjustment this subject had made. The most frequent symptoms in the mildly mentally ill group were memory defects, followed next by some delusional reactions. The findings on the psychotic will be reported below.

TABLE 2

DISTRIBUTION BY SEX AND MENTAL STATUS SHOWING MEAN AGE FOR EACH GROUP

	Male		Female		Total	
	Number	Mean age	Number	Mean age	Number	Mean age
Normal	40	75.1	7	74.7	47	75.1
Mildly mentally ill	14	74.2	9	75.2	23	74.5
Psychotic	28	76.1	23	75.4	51	75.8
Unclassified	5	73.4	0	...	5	73.4
Total	87	75.19	39	75.26	126	75.21

RESULTS

In Table 2 will be found data concerning age and sex of the 126 subjects (the oldest aged 96). Table 3 indicates the marital status, and Table 4 shows that this sampling consisted predominantly of subjects who had lived in rural districts most of their lives.

Table 5 records mental symptoms found in each of the 3 classification groups. As can be seen, contact could be established in only a third of the psychotics; in an additional

TABLE 3

MARITAL STATUS OF 126 ELDERLY COUNTY HOME RESIDENTS

	Normal		Mildly mentally ill		Psychotic		Unclassified		Total	
Living "single" lives	No.	%	No.	%	No.	%	No.	%	No.	%
Never married	29	61.7	12	52.2	25	49.0	3	60.0	69	54.8
Widowed	12*	25.5	9*	39.2	20	39.2	1	20.0	42	33.3
Divorced, separated	4*	8.5	1*	4.3	2	3.9	1	20.0	8	6.3
Total "single"	45	95.7	22	95.7	47	92.1	5	100.0	119	94.4
Married, spouse living	2	4.3	1	4.3	4	7.9	0	...	7	5.6
Grand total	47	100.0	23	100.0	51	100.0	5	100.0	126	100.0

* Of these 26 persons, 15 have been widowed, separated, or divorced for more than 10 years, 7 of these for more than 30 years.

TABLE 4

RESIDENCE DURING MOST OF LIFE OF 126 ELDERLY COUNTY HOME RESIDENTS

	Normal	Mildly mentally ill	Psychotic	Unclassified	Total No.	Total %
Farm	30	8	13	1	52	41.3
City	15	8	11	2	36	28.6
Both	1	2	3	0	6	4.8
Institution	..	5	14	..	19	15.0
?	1	..	10	2	13	10.3
Total	47	23	51	5	126	100.0

25% it was possible to establish only partial contact. It is therefore not surprising that hallucinations, which are usually more easily concealed than other mental symptoms, showed the highest percentage of questionable results. Definitely established mental symptoms were found in the following order of frequency: delusions 65%, confusion 57%, memory impairment 57%, orientation impairment 33%, hallucinations 29%.

Psychiatric Diagnoses.—Psychiatric diagnoses were available only for those subjects who had once been patients of the Mental Health Institute at Cherokee. Forty-three persons in this study were found to have had records there; 4 among them were without psychosis and are therefore not included in the 74 subjects of the mildly mentally ill and psychotic groups. In the latter groups are included 39 residents who were diagnosed as psychotic, constituting 54%. The rest, 46%, were never diagnosed and never seen by a psychiatrist. Table 6 lists the diagnoses in the order of frequency and shows the mean stay in years in county homes and in hospitals. The most frequent diagnosis was schizophrenia with 19 cases, followed by 12 subjects with manic-depressive psychosis. Some of these diagnoses are not compatible with contemporary classifications, while others are definitely erroneous. We can hardly accept a diagnosis of general paresis that was made 40 years ago. This patient, who was not treated, is still alive and does not show any particular symptoms of deterioration (see Table 6).

Length of Institutionalization.—The subject with the shortest period of institutionalization had been in the county home 1 day; the subject with the longest stay had been institutionalized in the county home and in a psychiatric hospital for a total of 55 years. Eight of the psychotics, or 16%, had been institutionalized for more than 40 years.

In Table 7 are listed the mean years of hospitalization separately for the diagnosed and for the undiagnosed psychoses. It is obvious that the real geriatric psychoses, those developing in advanced life, fall into the group of undiagnosed mental diseases. The fact that the elderly subjects are psychotic was apparently established, in a considerable number of cases, by nonpsychiatrists. Those who developed their psychoses in advanced life were in 95% of the cases not examined psychiatrically but taken directly to the county homes.

Of interest also is the fact that almost $\frac{2}{3}$ of the mentally ill persons had already been psychotic before their fortieth birthday, and reached old age in county homes; only 35% developed their psychoses in advanced life and can be classified as cases of real geriatric psychoses.

TABLE 5

PSYCHOTIC SYMPTOMS IN 126 ELDERLY COUNTY HOME RESIDENTS

	Normal		Mildly mentally ill		Psychotic		Unclassified	Total
	No.	%	No.	%	No.	%	No.	No.
Hallucinations								
Present	..	....	1	4.4	15	29.4	..	16
Absent	47	100.0	19	82.6	9	17.7	4	79
?	..	....	3	13.0	27	52.9	1	31
Delusions								
Present	..	....	1	4.4	33	64.7	..	34
Absent	47	100.0	17	73.9	7	13.7	3	74
?	..	....	5	21.7	11	21.6	2	18
Confusion								
Present	..	....	..	...	29	56.9	..	29
Absent	47	100.0	18	78.3	12	23.5	..	77
?	..	....	5	21.7	10	19.6	5	20
Orientation								
Yes	47	100.0	15	65.2	10	19.6	3	75
Partly	..	....	6	26.0	18	35.3	2	26
No	..	....	1	4.4	17	33.3	..	18
?	..	....	1	4.4	6	11.8	..	7
Memory								
Intact	36	76.6	11	47.8	5	9.8	..	52
Impaired	11	23.4	9	39.2	29	56.9	1	50
?	..	....	3	13.0	17	33.3	4	24
Contact								
Possible	47	100.0	21	91.3	17	33.3	..	85
Partly	..	....	2	8.7	13	25.5	5	20
No	..	....	..	...	19	37.3	..	19
Other *	..	....	..	...	2	3.9	..	2

* Not interviewed; information supplied by county home personnel only.

TABLE 6

HOSPITAL DIAGNOSES AND MEAN INSTITUTIONALIZATION IN 39 PREVIOUSLY HOSPITALIZED "MILDLY MENTALLY ILL" AND "PSYCHOTIC" ELDERLY COUNTY HOME RESIDENTS

Diagnosis	Number of subjects	Mean stay in years in county home and hospital
Schizophrenia (various types)	19	26
Manic-depressive (various types)	12	33
Paranoia	1	41
Alcoholic psychosis	1	43
Exhaustion psychosis, acute confusional insanity	1	40
Syphilis with meningo-encephalitis	1	13
General paresis *	1	40
Epileptic deterioration	1	29
Imbecility	1	7 †
Senile psychosis, paranoid type	1	6
Total	39	30

* No serological evidence.
† There was an interval of 30 years between the first and only hospitalization and admission to the county home.

Management of the Psychotic Patients.—Although it was not the immediate purpose of this survey to obtain information regarding the management of psychotic patients, the unit obtained an insight into the inner life of the county homes while spending several days in them. The average and larger sized homes have rooms and wards for untidy and disturbed residents. These are generally gloomy and dark. No psychiatric treatment is available, and the local doctor is rarely consulted on psychiatric problems. With the exception of 1 home, in which there is a registered nurse, no trained personnel is available. Some of the homes do not have the minimum of untrained attendants. Patients are often left unattended on the wards, especially at night. When a patient is considered difficult to manage he is sent to the state hospital. There is a constant exchange of patients between the 2 institutions, but in spite of this a considerable number of psychotic patients have never been examined in a psychiatric hospital.

The majority of the mental patients are kept locked up. Fifteen of the 74 psychotic and mildly mentally ill subjects were bedfast. Those who were not bedfast just sat around;

TABLE 7

DIAGNOSED AND UNDIAGNOSED PSYCHOSES IN 74 (23 "MILDLY MENTALLY ILL" AND 51 "PSYCHOTIC") ELDERLY COUNTY HOME RESIDENTS

Beginning of psychosis	Diagnosed psychoses		Undiagnosed psychoses		Total	
	No.	Mean stay in years in county home and hospital	No.	Mean stay in years in county home	No.	% of all psychoses
Early years	38	30	10	18.4	48	64.9
Advanced life	1	6	25	3.5	26	35.1
Total	39	..	35	...	74	100.0

⅔ of the psychotic subjects did not participate in any kind of activity or entertainment.

DISCUSSION

This survey covers about 6% of all elderly residents in Iowa county homes. Conditions found in the county homes during the survey are rather typical for the rest of this type of institution in the state. Moreover, it can be assumed that conditions observed in Iowa do not differ very much from those in other parts of this country. No accurate data are available as to the number of elderly psychotic residents in existent county homes. In some states—a very few—an attempt has been made to give the residents of this kind of institution slightly better-organized care. As a whole, however, it does not change the over-all picture. It can be assumed that there are at least 60,000 elderly residents in county homes or in similar institutions.[5] Of these, 30,000 are probably psychotic and receive substandard treatment.

The treatment of county home residents, the psychotic ones among them, is based on a conception that the aged mentally or physically ill are hopeless cases, that they need nothing but custodial care, and, last but not least, that the care should cost the community as little as possible. The county homes are therefore headed not by professional persons but by persons experienced in agricultural matters, by farmers. So it was in the past and so it is now. Members of the medical profession are certainly called in now more often than in the last century but this is for limited purposes only, mainly in the treatment of acute physical illnesses.

No doubt there is some progress as far as cleanliness and nutrition are concerned. There is an awareness of the need for trained nursing personnel. However, sufficient funds are not available. In addition, the unsatisfactory medical setup, coupled with the depressing atmosphere in the homes, discourages nurses from accepting positions or staying any length of time when they do accept them.

In spite of many unfavorable factors, the team found a group of psychotic and nonpsychotic people who had succeeded in reaching advanced life. About ⅓ of those studied were found to be in good physical health, but few of the residents were in a satisfactory psychological condition. The psychotics present a gloomy segment of the county home population. Contemporary practices such as occupational and recreational therapy and psychotherapy have not found entrance into the principles guiding those in charge of psychotic patients. Other methods of treatment that require greater professional knowledge or technical equipment are not even considered in connection with these psychotics.

CONCLUSION

This survey demonstrates the value of pilot studies of the kind described. They should be followed by other thorough investigations. Until recently the state hospitals were considered "end of the road" institutions. They are now going through a new development. We observe how slowly but firmly custodial

[5] By "county homes and similar institutions" is understood homes, with mixed age populations, maintained by local authorities. They are known by various names such as "county homes," "county farms," "county home and hospitals," poor farms," "poor houses," etc. The estimate of the number of elderly residents in such institutions is based on material available prior to publication of the 1950 census data.

psychiatry in state hospitals is changing to an active, continuous, treatment psychiatry. The really "end of the road" institutions, with far fewer facilities than state hospitals, are the county homes. This lost sector of psychotic, semipsychotic, and nonpsychotic persons should be included in the sphere of interest of contemporary psychiatry. Our belief is strong that, in spite of many handicaps, psychiatry can help to relieve the unnecessary suffering of a considerable number of the elderly residents and can stimulate the community to solve this problem in a more satisfactory way than it is doing at present.

INDIVIDUALIZING THE CARE OF THE AGING[1]

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The attempts of aging persons to preserve their individual independence and personal identity are, by their behavior, forcefully brought to our attention as their major concern. Their fears of losing these values are often observed to precipitate emotional difficulties long before there is actual physical or mental incapacity.

The time and degree of aging are becoming more generally recognized as individual and variable and not chronological. We speak of "aging" because there is no definite time at which one is aged. Some persons are old at 55 while others are physically well and mentally elastic at 75. Our cultural attitude generally places old age and sudden superannuation at retirement at about the age of 65. Although this conception is artificial its present importance is such that we shall need to accept it for our discussion. Many of the problems of people over 65 are not inevitable, but are imposed by this attitude. Social attitudes may make individuals old before their time.

The greatest need of the aging person is to feel that he is participating in life rather than merely existing. Increased longevity without work or interests, the gradual loss of friends, lonesomeness, and the feeling of not being useful or wanted is a cold and demoralizing prospect. It is a common observation that individuals who have no sustaining interests in life after their retirement from work are very soon likely to become depressed, disorganized, to go down hill rapidly both physically and mentally, and may soon become a family and social burden, or die.

Many people over the age of 65 have shown that they are perfectly able to work and do not wish to retire. Useful activity is the first need in the individual care of aging people. Measures are now being considered and should be encouraged to promote a continuation of part-time or modified employment in keeping with the person's wishes and capacities. This allows a tapering off of employment with a gradual transition to retirement when this becomes desirable. The record of older workers is good. In many instances their psychological traits have been found of particular value on the basis of skill, experience, judgment, responsibility, and dependability. The older person may have less absenteeism and his caution often makes him less accident-prone than many younger people. A national advisory committee on the industrial employment of older people has been formed by the American Geriatrics Society for the purpose of advising industry and labor on the working capacities of older people as individuals. It is hoped that the present tendency to employ older people, made necessary by the demands of the international situation, will crystallize and continue after this emergency.

Social recognition of the value and usefulness of aging people with opportunities for employment and activity consistent with their capacities and desires is necessary to solve the problems of our rapidly increasing aging population. In the United States, in 1950, persons 65 years of age or over numbered about 12½ million. It is reliably estimated that this number will probably reach 17 to 20 million by 1975(1) when a large proportion of our population will be over 45. The necessity of supporting the young plus the additional load of an increasing number of capable aging people will be an enormous burden to those of middle life and an unsatisfactory arrangement to those over the retirement age.

The practice of psychiatry in which we are particularly interested is naturally influenced by the age and corresponding needs of our population. The greater amount of psychiatric attention was at first paid to adults and then extended to children; in the future, increasing attention will be paid to the needs of the aging who will be more and more with us.

The aging person feels special need to preserve his individual identity in the face of social threats of uselessness and inactivity as well as those of organic dissolution. It is ap-

[1] Read at the 109th annual meeting of The American Psychiatric Association, May 4-8, 1953, Los Angeles, Calif.

parent that the care of aging people, both sick and well, requires particularly individualized attention to prevent and postpone personality disorganization and to stimulate and maintain their best level of functioning. It is far more helpful to think in terms of their capacities than their disabilities, although of course the latter must be understood and taken into practical account.

There is a significant difference in individual problems of personal identity as ordinarily experienced at various ages. The younger person strives for and expects to achieve individual independence; the emotionally mature adult has achieved these personal values sufficiently to share them altruistically with others. The aging person, however, when threatened by insecurity and dependency on family or society, often struggles asocially to conserve his individuality and self-interests for fear of their decline and irreparable loss. The fear of death often seems a lesser threat; one he can accept and, in some circumstances, one he seeks in a depressive suicidal attempt. The best way to assist the aging person is to promote his independence—help him to help himself for as long and to as great an extent as he is able.

The care of the aging has many facets. These are a heterogenous group of individuals. There are many people over 65 who are physically vigorous and psychologically alert, well adjusted, and emotionally comfortable; in the future no doubt the proportion will be larger. For convenience the others who require special attention may be considered in 3 categories. First, there are many persons without significant organic incapacity who present emotional problems usually of a psychoneurotic, depressive, or paranoid nature. Such common conditions are often precipitated by attitudes and experiences which, in a sense, could be considered consistent with difficulties encountered at their time of life. A second group shows definite organically determined physical or mental limitations that are not yet completely disabling. Their difficulties are varied in content and degree and, of course, emotional factors often play their part. Many have physical limitations which affect sensory acuity, such as deafness or reduced vision. Heart disease, high blood pressure, kidney disease, arthritis, cerebral arteriosclerosis, or beginning senile dementia may be present. There are many who do fairly well, perhaps with occasional mild periods of confusion or memory defect but who become much worse or even psychotic under the influence of toxic infectious factors or emotional stress. In a study of 100 patients consecutively admitted to the New York Hospital-Westchester Division, who suffered from psychosis with cerebral arteriosclerosis, it was found that emotional disturbances were the most frequent factors that seemed to upset their limited adjustment(2). A third group consists of those aging persons who are so mentally or physically impaired, or both, that they require continued care in a suitable hospital or perhaps a nursing home.

It appears that many of the problems of aging could be prevented or at least postponed. Generally, the first threatening situation to arise is that of retirement. It is becoming better understood that retirement is a phase of life for which preparation is necessary. The person who has cultivated no interests outside his work and who may be psychologically engrossed in an habitual, sometimes dull, and often compulsive struggle with life, is not well prepared for the more leisurely and casual habits of retirement.

The rigid driving person may be found to have obtained compensation in his work for old feelings of inadequacies that he has forgotten, but he has kept on in his pattern of life without learning the meaning of his inability to relax. He does not realize that he is unprepared to retire and cannot comprehend the difficulties of what he imagines will be a welcome relief from his cares. When retirement means, as it so often does, a loss of this emotionally charged compensatory occupation, the person can scarcely avoid feeling impotent and upset. The physician may, if he is given the opportunity, help the patient prepare for the anticipated letdown or perhaps a more gradual retirement by exploring his personality requirements with him. Dr. Edward B. Allen has aptly expressed the idea that a person must retire not *from* something but *to* something(3). Education and various mental hygiene programs seem to induce more older people to consult a physician

sooner than was the case in the past. Preventive medicine is a most important consideration in the individual care of the aging.

Our second general group of aging people who show organically determined physical or mental limitations short of complete disability often creates more difficult problems than the first partly because of increased conflicts over their dependency. Problems of finances, housing, and satisfactory activities are more acute because these people lack the capacity to meet the problems by themselves, yet they retain a more or less vivid awareness of their dependence. One of the most difficult situations at this time may be the relationship between the older person and his family, with whom he is likely to live. The security of the home adds a great deal to the well-being of the aging person. Unfortunate conflicts, however, may arise within the family. The older members may wish more attention and participation in family life often extending to the point of trying to direct family activities as had been the custom when the children were younger. The younger members, however, who are now supporting the home, may want less interference. They may even be critical of many real needs of an older person such as for higher room temperatures, special foods which he can tolerate, of occasional physical complaints, or emotional lability, regarding them entirely as a means of gaining attention. If the older person comes to actively exaggerate such needs as an instrument of hostility toward his family, the situation may actually become intolerable on both sides, with deep feelings of aggressiveness and consequent guilt, especially on the part of the younger members, and increased helplessness on the part of the older.

Families profit by making the effort to understand the individual needs of aging members. Often advice of the family doctor, in whom all members have confidence, is accepted. Such measures as separate quarters for the older person, the assignment of certain regular chores which will make him feel useful, the expectation that he will join the family at meals or in certain social events, reasonable attention to his special needs, attempts to enable him to understand the changes in the customs and manners of the children may be helpful to family harmony. With increasing urbanization, small living quarters, and more restriction of action than was the case with rural living, it may be impossible to maintain an aging person in the household. He may not even wish to remain there. In such situations the family may be helped to accept the need for him to be cared for elsewhere. Even then, frequent visits at home and close contact with the family are usually beneficial in maintaining the morale and personality integration of the older person.

Social and economic situations are of great importance to the aging person who is unable to work because of his impairment or who perhaps has the ability but is unable to find employment. Among the problems presented by such people are those of discovering and developing individual creative abilities and hobbies. The physician, often a psychiatrist, must be completely familiar with the facilities of community services to meet individual needs for suitable, available work, housing, financing, religious expression, recreation, adult education, nursing homes, hospitals, visiting nursing services, and other attention which may be required.

The aging person who has become grossly disabled either physically, mentally, or both can be conveniently considered in the third group mentioned. In what ways can his personality organization be maintained at its highest possible level? Often a person who is consistently mentally confused, who shows memory defects, poor judgment, emotional variability, deterioration of personal habits, and whose actions are difficult to influence, may need to be cared for in a hospital or at times in a nursing home. This is particularly true if there is, in addition, marked chronic physical disease. Frequently an ambivalent family has to be reassured of the need for this move even in extreme cases of disability since they are likely to feel guilty of abandoning the patient when he is helpless although when he was less obviously disabled they may have expressed more exasperation and hostility.

A well-regulated mental hospital program is of great benefit in ameliorating the conditions of even very deteriorated aging persons when they are treated on a special hall whose

functioning is geared to individual needs. The cases of 2 men patients are presented. They are discussed not for their uniqueness but because each indicates the effect of individual treatment, both psychiatric and physical, on stimulating and helping to preserve the personality of aging patients. The first patient was an individual showing marked organic mental deterioration but with good general physical health. The second patient had a functional mental disorder, a disabling physical condition, but little evidence of mental deterioration at the advanced age of 91.

CASE 1.—An 81-year-old retired successful professional man was admitted to the hospital because of many difficulties occasioned by gradually increasing disorientation, memory defect, poor judgment, restlessness, and repetitiousness for the previous 5 years. He required constant nursing care and it was impossible to manage him at home.

On admission his mental status showed a restless, uneasy man wandering aimlessly about the hall. He talked in a rambling manner, was disoriented for time, place, and person, and had gross memory defects. He could not remember the names of any of his associates and did not know where he was. He had considerable tendency to confabulate.

Physical examination revealed an elderly male in good general health, with a firm, steady gait and quick vigorous movements. He had evidence of slight arteriosclerotic changes in his radial vessels and second degree changes in his fundi. His heart and lungs were normal. His blood pressure was 160/75. Neurological examination was negative. His clinical laboratory examinations, including blood count, blood serology, urinalysis, and chest x-ray, were normal. The patient was considered to have a senile psychosis with simple deterioration.

Within a week following admission he had settled down comfortably on the hall. His personal appearance, with some assistance, was excellent and well-groomed. He was inclined to be circumstantial and amiably talkative. He particularly enjoyed talking with his physician with whom he would walk around the hall on rounds, asking questions and impressively giving advice even though it did not pertain to the situation at hand. He continued to show gross recent memory defect but retained some appreciation of past events which he liked to discuss with his physician. Disoriented, he spoke of being at a hotel. He occasionally stated that he was going to his club for a few days but added significantly that perhaps he would not go. Although unable to concentrate sufficiently in occupational therapy, he enjoyed walking and sitting on the grounds. He cooperated well on the hall routine with its regular rules, habits, and freedom from confusion.

In this case his relation with the physician, the nurses and aides, together with the high morale of the hall, contributed to the patient's ability to maintain his best level of adjustment with a contented mind and a feeling of security. Individual attention, which has an emotional meaning even to a mentally deteriorated patient, often sustains him much better than highly complicated procedures which do not meet such needs.

CASE 2.—The patient, a married man of 82, was admitted to the hospital with a recurrent depression. He was a man with many civic interests. At the age of 66 he had been treated at this hospital and recovered from involutional melancholia. His family history revealed long-lived stock with no psychopathy but with several unstable relatives. For 2 years the patient had been worried about financial difficulties and his future. His visionary and impractical personality had resulted in several business failures. He had been an impulsive, self-reliant, egotistical person who did not learn by experience. He was subject to vacillations of moods, was opinionated and liked his own way. He endured discomfort poorly.

Physical examination revealed a man of pyknic habitus who looked 20 years younger than his age and whose general health was good. His special senses were not particularly impaired except for a poor sense of smell. His hearing was good and his vision well corrected by glasses. He wore dental plates. His lungs showed moderate emphysema and blood pressure was 122/80. Clinical laboratory examinations were within normal limits.

Mentally he was depressed, preoccupied, and mildly agitated. He talked easily but was self-depreciatory, concerned with his sins, and at times retarded. He said he could not eat and that his bowels would not move. He confessed his guilt about present as well as past erotic thoughts and activities. His sensorium was clear and his memory intact. His insight and judgment were poor. He was considered to have manic-depressive psychosis, depressive type.

Within a week following admission he was more alert and active but continued depressed. Six weeks after admission, electric shock therapy was given with the use of intocostrin, and in the next month he was mentally improved. There was some residual memory defect which completely disappeared in a short time. Three months later he left on an extended visit, did some radio broadcasting and gave some lectures, but within 2 months again became depressed and wished to return to the hospital where he felt relieved. His condition has fluctuated somewhat since that time but he has been content to remain in the hospital.

Two years later he developed hematuria which required the removal of bladder calculi and he also had a partial prostatectomy for a benign enlargement. His spirits were fairly high following these procedures. He enjoyed talking about politics. Although he often wished to stay by himself it was noteworthy that he was always eager to talk to his doctor. In 1949 he had a severe gastrointestinal hemorrhage with a mild state of shock due to peptic ulcer. It was decided to treat this condition conservatively; after 3 months he had recovered with

no further trouble. Later in 1949, however, he had a left hemiplegia which left him incapacitated for most physical activities. Now, in spite of his hemiplegia, and other difficulties, he reads voraciously, does some writing, enjoys making sharp and witty literary criticisms, and remains mentally clear at the age of 91.

This patient shows the value of individual treatment in a rather crotchety person who is completely dependent upon his care, is likely to criticize it but nevertheless shows that he appreciates the many attentions that he receives, and has marked emotional dependence on the hospital and staff. Although physically incapacitated, with mild fluctuations of moods, he remains mentally clear. He is able to continue relatively comfortable at an optimum level of personality organization despite serious limitations at an advanced age.

Summary

Fear of losing independence and individual identity precipitates emotional difficulties in aging people. These disturbances often occur long before actual incapacity. The time and degree of aging is individual. Our cultural attitude generally and artificially places it at retirement after the age of 65. Many problems of aging are now imposed rather than inevitable. Such problems require individual attention to prevent personality disorganization and to stimulate the best level of functioning in those with different degrees of organic physical or mental incapacity.

Social recognition of the value and usefulness of aging people with opportunities for employment and security consistent with their capacities and desires are necessary to solve the problems of a tremendously increasing aging population. Such advantages must be related to individual needs. Families need to understand their aging members. The physician, often a psychiatrist, must be completely familiar with the facilities of community services to meet individual needs for employment, financing, housing, religion, adult education, nursing homes, hospitals and medical attention.

Individualized care supports the morale and personality integration of those in their own homes, homes for the aging, or in hospitals including those for mental disorders. An environment without too much change or too many new people often enables confused patients to maintain a relatively clear sensorium. The aging should not be submerged in routine but should be encouraged, when capable, in hobbies or productive chores. They should be allowed some cherished possessions of their own for stability and reassurance offered by continuity with memories of the past. Personal relationships are a great support. Short walks, sitting outdoors, and recreation evoke interest. Maintenance of health habits and personal appearance are essential. The cases of 2 aged hospital patients are presented.

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OFFICIAL REPORTS

ANNUAL MEETING OF THE WORLD FEDERATION FOR MENTAL HEALTH

The 1953 annual meeting of the World Federation for Mental Health was held in Vienna, August 16-22. In 2 specific ways this meeting was a distinct step forward in the development of that organization. First of all, it accomplished what was hoped in locating it in Vienna. An annual meeting is held in countries where there is good prospect of strengthening the national mental health association. In Vienna, the Austrian Association did itself proud in making excellent arrangements. The meeting provided that Association with a definite and concrete focus which tended to weld it together more strongly. The meetings of the Federation were held at the University of Vienna under the general leadership of Dr. Hans Hoff, professor of psychiatry.

Public officials participated to an unusual extent, some of them appearing several times, and it was very evident that they were impressed by the needs and opportunities in this field. The meeting was attended by over 400 persons, many of whom were accustomed to thinking within the range of international matters.

In addition to strengthening the national association for mental health, the annual meeting added new recruits to those already interested in world affairs. This came about especially in the group sessions. Heretofore, these working groups, of which there were 15 or so, concentrated on the production of a report on one or another aspect of the field of mental health. There is, however, some question as to the value of a report produced in so short a time by a group that had not worked together before. In the 1953 meeting the objective was somewhat changed, and the report was thought of more as a means of drawing the participants together to think and work in terms of world needs and conditions.

There is no question that in the past 4 or 5 years these annual meetings of the World Federation have greatly increased the number of persons who are capable of functioning with this broader perspective.

It was interesting in some of the meetings to see a shift from local or national to international perspective take place. In one session a participant began with the apparent feeling that he needed to stand as a spokesman for his own country. As the meeting progressed, and he found that others were not being quite so provincial and promotional, his position also softened. There was a problem with those who were not accustomed to free discussion. They apparently felt considerable anxiety at not being able to make speeches. In fact, some actually relieved their anxiety by making them.

The scientific part of the meeting was presented in either German or English, with translations into the alternate language. The meeting consisted of plenary sessions in which special topics were presented and discussed. At one of the plenary sessions there was a review of progress in mental health in several continents.

The formal program was considerably varied. One of the outstanding presentations was by Dr. Maria Pfister, a report of her 4 years' work with refugees. Of interest also is the fact that 3 delegates from Russia attended the meeting, bringing with them formal papers which were more appropriate for a professional meeting of psychiatrists. Nevertheless, a place was made for them. They spoke in German, with simultaneous interpretation into English, and their papers were translated into English, duplicated, and passed around to the audience.

Among the presentations was an English film showing the psychological effects of hospitalization upon a child, in this case for repair of a hernia. As a result of this film many hospitals have changed their visiting privileges for parents in order that the psychological damage to the child may be minimal. Mental health associations elsewhere are interested in liberalizing visiting regulations in behalf of the mental health of pediatric cases.

Another presentation showed the detrimen-

tal effects of institutionalization upon otherwise normal children. The accompanying film showed in these children behavior disturbances similar to those of idiots. We have tended to think of the rocking habits of idiots as an inherent part of the mental deficiency. It may instead be a superimposed characteristic brought about by their psychological isolation. This work may lead to some experimental approaches to the handling of children of very low intelligence, so that these possibly reactive effects can be eliminated. In other words, we can begin to speak of therapy with the low-grade mentally deficient. Perhaps I should not say "begin." This approach to children of low-grade deficiency is not new in this country. The work of Dr. L. Pierce Clark has, however, been forgotten more or less for some 25 years and with this new impetus it may possibly revive.

As I have said, participants in the annual meeting were divided into working groups, each of which had 3 sessions. I participated in the group on mental health problems of refugees. These problems are probably closely related to those of migrant workers and other displaced persons, *e.g.,* Puerto Ricans, and the mental health work that has been done with refugees should be carefully inspected for potential values in meeting the problems of migrants.

The program for the International Congress on Mental Health to be held in Toronto next year received consideration. In anticipation of this Congress, the National Association for Mental Health of the United States is undertaking to convene a special commission which will present a report on the mental health needs of the country. The first meeting of this commission will be held at the time of the annual meeting of the National Association in Cleveland.

It is planned, subsequent to this Congress, for representatives of national associations to meet in order to draw out of the Congress experiences of value to national associations for mental health.

The new President of the World Federation is Professor H. C. Rumke, professor of psychiatry at the University of Utrecht and Rector of the University. The Vice-President, and President for next year, is Dr. Frank Fremont-Smith of the United States. The undersigned continues as Treasurer.

The following member associations were represented at the Vienna meeting:

American Neurological Association, American Psychoanalytic Association, American Orthopsychiatric Association, American Sociometric Association, Canadian Association for Mental Health, Liga Mexicana de Salud Mental, Menninger Foundation, National Association for Mental Health, National League for Nursing, and The American Psychiatric Association.

The official duties of a delegate of a member association of the World Federation are highly important, and their participation is essential, since they represent the basic authority of the organization. The national delegations cast one vote for the Board of Directors and officers. It should be recognized that officers or members of the Board of Directors are not spokesmen for the countries from which they come, for with a board of 15 persons it is impossible for all countries to be represented and each member of the Board must, therefore, serve in an international capacity. Dr. Paul Friedman, representing the American Psychoanalytic Association, was chosen to cast the vote of members from the United States.

Elected to the Board for a 3-year term were: Dr. Hans Hoff (Austria), Miss. I. Marwick (South Africa), Lady Norman (United Kingdom), and Prof. Pacheco y Silva (Brazil). Substitute members of the Board elected for one year include: Miss Daisy Bridges (United Kingdom), Mr. Cato Hambro (Norway), Dr. Phon Sangsingkeo (Thailand), Dr. Helgi Tomasson (Iceland), Dr. Paul Sivadon (France), and Dr. D. R. McCalman (United Kingdom). Of course, Dr. Bartemeier will continue to serve until the expiration of his term next year. The Board has, therefore, been broadened and, in addition to psychiatrists, it includes one psychologist, one layman, one public health official, and one nurse.

One important step taken was the establishment of a Committee of Honor to include the sages of our field who have more or less retired. Six were chosen from the United States, two being members of The American Psychiatric Association—Dr. William Healy

and Dr. Ellen C. Potter. The others are Dr. Haven Emerson, Dr. C.-E. A. Winslow, Mr. Homer Folks, and Mrs. Clifford W. Beers.

As to finances, the situation of the World Federation is as follows: For the year 1954 there is assurance of $24,000 and for 1955 $20,000. With a minimum budget of $64,000 this means that a considerable amount will have to be raised if the Federation is to operate with any degree of efficiency, or to undertake development of a program of consultation with member associations, provide information and other services.

GEORGE S. STEVENSON, M. D.

THE MOB MIND

Beliefs rest for the most part on foundations which arguments cannot reach—on feelings, habits, prejudices, the bias of interests and of wishes and of fears, and they change without reason when the substratum of feeling in which they are rooted changes. All history shows that revolutions of popular belief have not taken place gradually in consequence of the assaults of reason, but suddenly from no immediate help of reason, in consequence of a certain change of sentiment that has been insensibly brought about: the multitude which is shouting acclamations at its hero one day is howling execrations at him on another day, and could give not intelligent reason either for its adoration or its hatred, or for the change from the one to the other. The effect of mental infection, when enthusiasm is inflamed, is to cause multitudes to think and howl together, as jackals hunt, in packs. It is as with the spread of a conflagration; the heat of the burning part raises the adjacent parts to a temperature at which they easily catch fire, and so one earnest fool makes many fools.

—HENRY MAUDSLEY,
The Pathology of the Mind

PRESIDENT'S PAGE

The American Psychiatric Association has worked for over a hundred years to improve the care and treatment of the mentally ill. The formation of the Committee on Certification of Mental Hospital Administrators is another indication that the Association is mindful of its goals and is alert to opportunities to actualize them.

At the time of the birth of the Association there was considerable divergence of opinion as to who should be the chief executive officers of organizations or facilities which later became mental hospitals. Up to that time institutions for the mentally ill were under the control of church groups or political subdivisions of government. The founders of this Association felt as we do now that it was in the best interest of patients that physicians, and later psychiatrists, be the chief executive officers of mental hospitals. This Association has continued to maintain this basic principle.

In the past, mental hospital administrators received their training by preceptorship. While this has produced many outstanding mental hospital administrators, it has not been able to meet the growing demand for psychiatrists with administrative ability. It has became apparent that the preceptorship method needs to be supplemented by more formal processes of training in the nonmedical aspects of hospital administration.

The Association has always regarded it as unwise and unsound to separate the "administrative" from the "medical" aspects of mental hospital operations and to confine the physician's responsibility to the latter. The American Psychiatric Association believes that all mental hospital operations have an important and direct relationship with the therapeutic progress of patients and that accordingly only a physician should assume total responsibility for them. This position is set forth without prejudice to that large body of laymen who serve as skilled and indispensable executive assistants to the physician-administrators of the mental hospitals of the United States and Canada.

In 1951 it was brought to the attention of the Council that if our policy regarding the chief executive officers of mental hospitals were to be maintained, it was incumbent upon this Association to consider how mental hospital administration could be improved; how suitable recognition could be given to superintendents of experience and stature; how physicians could be certified as qualified in this field; and how this specialized area of medical practice could be made more attractive to young psychiatrists.

An *ad hoc* committee was appointed to study these problems. The committee, through correspondence, conferences, and questionnaires, thoroughly investigated the training standards and optimal qualifications for mental hospital administrators and studied methods of certifying them as qualified. On the basis of this committee's recommendation, the Council and the membership of the Association on May 6, 1953, approved the establishment of a permanent committee on certification of mental hospital administrators. The members of the committee were appointed shortly thereafter by the President. The committee is now at work setting up policies, procedures, regulations, and methods for examination and certification.

This board, composed of eminent psychiatrists and consultants, under the guidance of Dr. Francis J. Braceland as President and Dr. Crawford Baganz as secretary, seems assured of making an important contribution to psychiatry in this continent.

KENNETH E. APPEL, M. D.

COMMENT

COLLEGE MENTAL HYGIENE SERVICES

Since the turn of the century, there has been growing interest in, and demand for, mental hygiene services among American colleges and universities. The trend has become progressively more marked during the past 15 or 20 years. On the basis of a questionnaire survey in 1936,[1] with almost 500 colleges replying, 93% indicated attention along mental hygiene lines to be an important need. Likewise, 41% of these institutions reported some type of service of this kind already existing, and 45% more were interested in the establishment of such services. On the basis of a later survey,[2] 550 psychiatrists were found to be giving some time to work of this kind, although only 25 were full time. Further, it has been reported that at least 10% of students request help of this type. Of significance also is it that in recent years there has been increasing interest in other countries, and especially in the British Isles where the matter has evoked considerable attention, but with still very little accomplished in a specific professional and organized way in dealing with the problem.

The subject deserves serious consideration, particularly in the light of the finding that more than half of all students who enter college do not remain long enough to graduate. However, even in the United States where interest and activity have been of considerable duration, the problem is very far from being solved. There are many institutions without provision and, among those having some facility, there is considerable diversity as to effectiveness, setup, and the type of personnel involved, among others, psychiatrists, general physicians, psychologists, social workers, religious advisers, nurses, deans of students, and interested faculty members.

In view of the large number of collegiate institutions and the relatively small number of psychiatrists in the national community, it is rather unrealistic to proceed with the idea of providing exclusive psychiatric service for all, even if this were desirable. Moreover, for most college budgets, the expense involved is prohibitive; and besides, the usual training for psychiatrists is by no means specifically preparative for this work, considering the special nature of the clinical material, the age range, and the specific problems, demands, and exigencies of the college context, academically and otherwise. Further, with respect to many institutions, aside from budgetary considerations, there is not sufficient enrollment to justify full-time psychiatric personnel, even if obtainable. It should be mentioned, too, that there has been increasing interest and entry of nonmedical workers into the field, more particularly psychologists and psychiatric social workers. Again, for these groups there are limitations in view of the nature of the preparation and the absence of the holistic experience gained through medical training.

The point presents itself that this work perhaps may represent a special field in itself, falling in the common ground between psychiatry and certain nonmedical spheres, as clinical psychology, psychiatric social work, and the various categories of guidance. The desirability is suggested therefore of defining a special professional area or category, which might be termed clinical counseling, based upon and drawing from the knowledge, thinking, and experience of all the fields mentioned and specifically geared to dealing with student problems. Toward this end, special training plans should be worked out, integrating in a functional interdisciplinary way the pertinent aspects of the various areas involved, more particularly, of course, those of medicine, psychology, and social work. In this way, the medical and social needs could be much more readily and fully met, and the specifically oriented psychiatrist utilized more on a directional and consultational basis and for special cases, part time or full time.

[1] Raphael, T. Mental hygiene services for Colleges and Universities. Mental Hygiene, 21: 559, Oct. 1937.

[2] The Role of Psychiatrists in Colleges and Universities, Report 17, Sept. 1950, Committee on Academic Function, Group for the Advancement of Psychiatry, Topeka, Kansas.

At any rate it must be recognized that a special professional need exists in the program for solving a very pressing and still rather confused problem. In principle too, it might be added, the foregoing might well have bearing for other fields of social relations as probation work, the pastoral function, industry, and others.

T. R.

NO PSYCHOSURGERY IN THE U.S.S.R.

The following translation of an order of the Soviet Ministry of Health, appearing in the publication *Neuropathology and Psychiatry,* has been provided by Dr. Ronald Hargreaves of the World Health Organization. Dr. Hargreaves sent this document to Dr. Bartemeier who had kindly transmitted it. It is clear enough for him who runs to read.

Order of the Ministry of Health of the U.S.S.R.

On the initiative of Prof. M. A. Goldberger (Gorky Medical Institute), Prof. A. S. Shmaryana (Central Institute of Psychiatry, RSFSR) and Prof R. Ya. Golant (Leningrad Institute of Psychiatry) treatment of neuropsychiatric diseases by means of prefrontal leucotomy was begun, although the theoretical, clinical, and experimental bases are inadequate.

Trials of the therapeutic effectiveness of this method and study of its remote effects showed that it not only has no advantage over other methods of curing these diseases but causes undesirable organic changes which prevent further therapy.

The Medical Council of the Ministry of Health of the USSR at its session on November 30 of this year considered the question of prefrontal leucotomy as a therapeutic method and recognized this operation as being theoretically unsound; the use of prefrontal leucotomy for treating neuropsychiatric illnesses conflicts with the basic principles of the physiologist I. P. Pavlov.

In accordance with the decision of the Medical Council the Ministry of Health of the USSR of November 30, 1950:

1. The use of prefrontal leucotomy for neuropsychiatric diseases is forbidden.

2. It is the duty of the Ministries of Health of the United Republics, in control of health in counties, districts, and boroughs, stringently to enforce Point 1 of the present order and henceforth to prohibit the use of prefrontal leucotomy for the treatment of neuropsychiatric diseases in medical institutions.

3. Control of the carrying-out of the present order shall be the responsibility of the Chief Administrator of muncipal institutions, Comrade D. D. Fedotov.

Signed: E. Smirnov.
Minister of Health of the USSR.

Neuropatologiya i Psikhiatriya
(1951) 20, 1F

Dr. Hargreaves quoted also a lengthy criticism of the theory of leucotomy by Khachaturyan which appeared in *Neuropathology and Psychiatry* (20, (1) 18, 1951), wherein the opinions of numerous Russian authors were cited. The misguided tendencies of a few to listen to Western teaching were exposed and castigated; otherwise there was unanimous agreement that foreign theories re psychosurgery were unsound and diametrically opposed to the clear teachings of Pavlov. The dutiful Soviet psychiatrists registered their unswerving adhesion to the official version of Pavlovian doctrine and their emphatic opposition to the reckless, capitalistic surgical adventuring of Western doctors.

NEWS AND NOTES

Death of Dr. Brennan.—The many friends of Dr. Edward L. Brennan were distressed to learn of his sudden and untimely death on September 27, 1953. He was in the private practice of psychiatry in Hartford, also director of the outpatient clinic at Saint Francis Hospital and attending psychiatrist at the Veterans Hospital, Northampton. Cofounder of the Guild of Catholic Psychiatrists, he was a diplomate of the American Board of Psychiatry and Neurology, and has been a fellow of The American Psychiatric Association since 1939.

Dr. Brannan was born in County Carlow, Ireland. He attended Summerhill College and the National University of Ireland. He came to the United States in the late 1920's, joined the staff of the Vanderbilt Clinic in New York City as attending psychiatrist and was also an instructor at Columbia University. He joined the late Dr. Burlingame in Hartford in 1938 and became a staff psychiatrist and later executive officer of the Institute of Living.

Dr. Brennan was a hard worker and spent long hours in his office and his clinic. His love of his work was second only to his devotion to his family. His 2 children are following him in the profession of medicine. On the conservative side of things psychiatric, he was fully aware of everything that was going on in his specialty. The newspapers wrote his epitaph well when they said that "there were many people quietly dependent upon him" and it was known that he had a love of "little people." He interested himself in his patients beyond their medical and psychiatric problems and he treated them with kindness and charity. In his death medicine and psychiatry lost a sincere, hard-working physician who lived up to all the ideals of his profession.

Dr. Appleton H. Pierce Dies.—Dr. Pierce, consultant in psychiatry at the mental hygiene clinic of the Veterans Administration office at Miami since 1946, died in Leominster, Massachusetts, September 25, 1953, at the age of 83.

Graduating from Harvard, M. Ed., 1889, and M. D., 1895, Dr. Pierce interned at the Worcester City Hospital. He was a medical officer and clinical director of the USPHS Hospital in West Roxbury, Massachusetts, from 1920 to 1924, then joined the Veterans Administration in Northampton where he remained 6 years, after which he served as manager of the VA in Coatesville, Pennsylvania, until 1943, when he accepted the position of assistant superintendent of the Philadelphia State Hospital, in which post he continued until 1946. He published many articles on occupational and recreational therapy in the Veterans Administration.

Dr. Pierce was a fine gentleman who impressed his associates by his sincerity and wisdom. He never failed any who needed his help. He was an examplar of the "art of living" the good life, and he endeared himself particularly to those whose fortune it was to work with him.

The Allan Memorial Institute of Psychiatry.—On October 21, 1953, the new wing of the Allan Memorial Institute, which is an integral part of the Royal Victoria Hospital in Montreal, was formally opened. Built to meet the demands for treatment which come from all over Canada and beyond, the new building expresses the basic policy of the Institute—that of a completely open hospital and identical in this respect with the parent institution, the Royal Victoria Hospital. The enlarged Institute will be able to provide under optimum conditions the most advanced therapy available and particularly psychotherapy.

The old building is being extensively remodelled to offer greatly increased ambulant services. The director, Dr. D. Ewen Cameron states that when the alterations and addition are completed, the new Allan Memorial Institute will be able to provide inpatient and ambulant services to about 250 patients daily.

Dr. Nolan Lewis Assumes New Post.—As of August 30, 1953, Dr. Nolan D. C. Lewis resigned from the directorship of the

New York State Psychiatric Institute and the professorship of psychiatry in the College of Physicians and Surgeons, Columbia University, in order to accept the position of director of research in neurology and psychiatry in the newly organized New Jersey Neuropsychiatric Institute at Skillman. Dr. Lewis took this action by reason of his wish to return to personal, intensive research, relieved of the onerous duties of hospital administration and teaching routine.

Dr. Lewis has had a remarkable career as original investigator and reporter, teacher, administrator, and editor; and in his new post will return to the kind of work in which, from first to last, he has been most interested. Both he and the New Jersey service are fortunate in the new association.

Galesburg State Research Hospital.—On October 17, 1953, was dedicated the Thudichum Psychiatric Research Laboratory at the Galesburg (Illinois) State Research Hospital. This laboratory is named in honor of John Lewis William Thudichum, M. D., F. R. C. P. (1828-1901), founder of brain chemistry. Dr. Thudichum was born in Germany and went to England at the age of 23 and remained there during the rest of his life. His pathfinding book, *Chemical Constitution of the Brain,* was published in 1884.

Dr. R. J. Graff, superintendent of the Galesburg Research Hospital, and other distinguished speakers presented a scientific program to mark the dedication ceremonies.

Dr. Louis Casamajor Honored.—Dr. Louis Casamajor, professor emeritus of clinical neurology at Columbia University and consultant at the Presbyterian hospital, was one of 25 individuals who received distinguished service awards in connection with the twenty-fifth anniversary of the Columbia-Presbyterian Medical Center, October 12-13, 1953. These awards, first of the kind made by the institution, commemorated contributions by Dr. Casamajor and his colleagues to the growth and development of the medical center.

Dr. Casamajor was a member of the teaching staff of the medical center from 1914 to 1948. He is a former president of the New York State Neurological Society, the New York State Society for Clinical Psychiatry, and the New York Psychiatric Society. In 1952, he was awarded the Congressional Selective Service Medal.

Yale Department of Psychiatry.—In the notice (October issue) of the appointment of Dr. Norman Cameron to the staff in psychiatry at Yale, an erroneous impression was conveyed. The Department of Psychiatry is represented by 3 full professorships: Dr. Theodore Lidz is psychiatrist-in-chief of the Grace-New Haven Community Hospital; Dr. Norman Cameron, recently appointed, will continue at Yale his research in behavior pathology; Dr. Redlich continues as Chairman of the Department.

South African Medical Journal.—The September 19, 1953, issue of this publication contains a number of summary articles on psychological medicine which are of considerable interest. These papers were read at the plenary session on psychological illness at the South African Medical Congress held in Johannesburg, September 1952. The contributions deal with psychiatric problems in South Africa, with mental hospitals and extramural treatment facilities, psychological ills of childhood and psychological problems in surgery, and with the question of mind-body relationships.

Psychosomatic Institute at Topeka.—Specialists in psychosomatic medicine will present a special 3-day institute on emotions and the female reproductive system at the Topeka psychiatric hospitals, December 10-12, 1953. The institute, sponsored by The Menninger Foundation and the University of Kansas Medical Center, will be presented with the cooperation of Winter Veterans Administration Hospital, Topeka State Hospital, the Kansas State Board of Health, and the Kansas Medical Society.

Enrollment is open to all practicing physicians in the Mid-West, but must be limited to 80. Further information concerning registration may be obtained from Harold Ingham, Extension Program in Medicine, University of Kansas Medical Center, Kansas City, Kansas. A fee of $30.00 is charged to help cover the program and administrative costs. Complimentary enrollment is granted

to interns and residents upon identification by their hospital superintendents.

New York State Schools of Psychiatric Nursing.—The affiiliation program for students in the New York State Department of Mental Hygiene schools of nursing has been considerably expanded for those entering the 1953-54 class. Some 200 students enrolled at 13 of the Department's schools will enter as freshmen in 8 colleges and universities in the state. They will attend college 4 days a week, taking same courses and enjoying the same privileges as the regular science students. From the beginning of the 3-year course the arts of nursing will be taught at the home hospital.

Dr. Kretschmer Honored.—In the October 2, 1953, issue of the *Deutsche Medizinische Wochenschrift,* Dr. J. Hirschmann of Tübingen is the author of a tribute to Prof. Ernst Kretschmer, professor of psychiatry in the University of Tübingen, on the occasion of his sixty-fifth birthday (October 8, 1953). He gives an outline of Dr. Kretchmer's professional career and emphasizes his special contribution as a pioneer in the study of constitution and its relation to mental disorders and in the general field of psychotherapy. Many colleagues and students, both at home and abroad, owe their training and guidance to Prof. Kretschmer as director of the Neurologic Clinic of the University of Tübingen. His textbook of medical psychology is an authority in German-speaking countries and in translations in countries abroad.

An Electric Shock Fatality.—In the special mental hygiene number of the *Delaware State Medical Journal* (August 1953), prepared annually by the superintendent and staff of the Delaware State Hospital, Dr. George S. Rogg reports the case of a 50-year-old female patient who died 35 minutes after receiving her second electroconvulsive treatment. Several mental symptoms had been present some 4 months; the patient was obese. There were large, superficial ulcers over both legs with moderate varicose veins. Postmortem examination showed a left pulmonary embolus of the diameter of a pencil, and 2 inches long, and was listed as the cause of death.

The author suggests that while many patients with varicose veins have been given shock treatment without following difficulty, it may be worth while to consider such possibilities when varicose veins are present.

Ninth Inter-American Medical Congress.—More than 2,500 doctors and medical researchers from 22 nations of the Western Hemisphere will exchange information on the latest developments in medicine, surgery, and related fields during a 16-day medical congress to be held in 6 South American ports and en route from New York to this year's conference cities, Caracas, San Juan, Ciudad Trujillo, St. Thomas, and Havana. Over 700 U. S. representatives to the congress, sponsored by the Pan-American Medical Association, will sail from New York, January 6, 1953, to meet with their colleagues in South America.

Further information may be obtained by writing Dr. Charles Crocker, Executive Secretary, Pan-American Medical Association, San Francisco, California.

This world is a comedy to those who think, a tragedy to those who feel.
—Horace Walpole,
Letter to Horace Mann, 1772.

BOOK REVIEWS

ATLAS OF ELECTROENCEPHALOGRAPHY, VOLUME II. EPILEPSY. By *Frederick A. Gibbs, M.D.* and *Erna L. Gibbs* (Cambridge: Addison-Wesley Press, Inc., 1952. Price: $25.00.)

This is the second volume of a 3-volume atlas and deals entirely with the subject of epilepsy, not only electroencephalographic findings, but it also contains a wealth of clinical material of interest to anyone concerned with the diagnosis and treatment of convulsive disorders.

After a brief historical survey and some general statements concerning the relationship of electroencephalography to convulsive disorders, the authors discuss the neurophysiology of the seizure discharge. A brief review of neurophysiological terms and fundamental concepts is followed by a review of recent work on experimental convulsions and seizure discharges in animals. The effects of electrical stimulation are treated extensively as well as the influence of chemical substances and physical agents that excite or inhibit the convulsive phenomena. Efforts to stimulate in experimental animals the various types of clinically recognized seizures are discussed in some detail. The authors next deal with the pathogenesis of epilepsy. They recognize that the precise biochemical basis of the disorder remains obscure. This chapter, while highly theoretical, is a stimulating discussion and contains some ingenious diagrams illustrating their concepts of the pathogenesis of the disorder and of the influence of a wide variety of factors that are believed to play a role in the epileptic state.

The chapter on the clinical correlates of paroxysmal cerebral dysrhythmia is a faithful presentation of the authors' well-known point of view on this subject. Some of the statements concerning correlations between specific wave forms in the interseizure record and specific clinical forms of epilepsy are not generally accepted by many competent workers in the field.

The clinical material on which the volume is based consists of 11,612 cases of which 5,638 were studied in sleep. Each of the diagnostic entities the authors recognize is then discussed in a separate chapter. These include, first, infantile spasms, the associated electroencephalographic abnormality of which the authors call hypsarhythmia. In other chapters the clinical entities and the electroencephalographic abnormalities that are frequent accompaniments are given identical terms leading to continued confusion and requiring constantly qualifying legends in diagrams, tables, and text. It is often difficult to tell whether the authors are referring to petit mal epilepsy as a clinical entity or the 3-per-second spike-and-wave pattern which the authors persist in calling petit mal. This confusion of terminology is inescapable and is the reason most electroencephalographers studiously avoid using terms applied to specific clinical entities when describing the shape, frequency, and amplitude of waves seen in the EEG. This criticism of the terminology of the Gibbs school has been made so frequently in the past that it is unfortunate that the authors have not substituted terms for the electroencephalographic abnormality that would clearly differentiate it from the clinical condition in grand mal, psychomotor, and petit mal. They are to be commended that in the clinical entities of infantile spasm, Jacksonian and focal seizures, and in thalamic and hypothalamic epilepsy, the electroencephalographic abnormalities that the authors have found to be present frequently in these disorders are designated by purely descriptive terms.

The chapters on each of the clinical entities enumerated above are complete discussions of these varieties of seizure as seen in this large group of patients. There are numerous excellent diagrams and tables giving statistical data not only on the type of electroencephalographic abnormality but on the age incidence, types of auras, the presumed etiology, the neurological signs and symptoms, and psychiatric observations. The detailed classification of these many features of this large group of clinical varieties of convulsive disorders is one of great value to the epileptologist. The text also includes a brief discussion of drug therapy as relating to each clinical entity as well as a separate chapter on activation techniques, medical and surgical therapy.

Valuable as the text is, the greatest contribution the atlas affords is the many full-size reproductions of waking and sleep records seen in all of the varieties of clinical epilepsies. It is in the faithful reproduction of these abnormalities of electroencephalographic records that the book has its greatest value. These tracings are the raw data that will never change no matter who wishes to argue with the authors about terminology, interpretation, and therapy.

The bibliography, arranged alphabetically, contains close to 1,000 references and there is an excellent index with references to the text and to the plate number of the electroencephalographic record as well. The paper binding and printing are first-class.

The book represents a work of which the authors may be justly proud. No electroencephalographer or neurologist who is interested in the diagnosis and treatment of convulsive disorders should be without this atlas.

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DIAGNOSTIC ELECTROENCEPHALOGRAPHY. By *Hans Strauss, M.D., Mortimer Ostow, M.D., M.S.C.D., and Louis Greenstein, M.D.* (New York: Grune & Stratton, 1952. Price: $7.75.)

Electroencephalography is still in a stage of rapid growth. Its methodology, its specific clinical sig-

nificance, its differential interpretation still depend a great deal upon individual approach and experience. This is why each new trial to present a systematic account of EEG procedures and methods constitutes more than a didactic effort of conveying to the student the fundamentals of this method of neurological investigation. Almost every recent book in EEG summarizes a personal experience, analyzed through a prism colored by a particular neurophysiological or neuropsychiatric background, aiming to satisfy specific needs of a certain population of patients. The monograph written by Dr. Hans Strauss and his close associates, based on considerable firsthand information, gathered in a large hospital (New York Mount Sinai) with active neurological and neurosurgical departments, represents a valuble contribution, because of both the weight of their experience and the originality of their method in evaluation of EEG abnormalities.

The first part of the book deals with the general aspects of electroencephalography: equipment, recording, artefacts, characteristics of the normal and abnormal EEG considered under different conditions. This chapter constitutes a successful attempt to help the beginner in his initiation to the EEG technic. An original classification of abnormal records is offered, purposely underestimating such unusual features as can be found in purely "functional" disorders. Thus, fast activity and 7-per-second rhythm are presumably excluded from the criteria of abnormality. The beginner will find, however, in another chapter, the reference to incidence of fast activity in barbiturate intoxication and in psychiatric disorders that may contribute to the evaluation of such records. The authors' criteria of "organic" abnormalities are based on both the amount of delta activity above a certain critical level and the degree of asymmetries of the alpha rhythm.

A delta factor expressing the amount of delta rhythm from 6-per-second down is determined separately for each lead; its average value is computed for each hemisphere. Samples of different types of abnormalities, designated by an ingenious system of symbols, are given at the end of the volume.

Pronounced and moderate focal, asymmetrical, parasymmetrical, shifting, and diffuse abnormalities are considered as occurring either continually or intermittently with or without bursts. Differentiation of spike-and-waves, in regard to their frequency, was not found of useful clinical significance. The occurrence of spikes (which were only rarely present in their population for some not entirely explainable reasons) has not been submitted to statistical analysis.

The second and third parts of this book are related to the statistical elaboration of the incidence of these different abnormalities under various clinical conditions on the basis of the authors' experience and critically compared with the reviewed findings gathered in other laboratories. Personal data are presented in numerous tables in which incidence of the abnormality is given for each disease.

This is undoubtedly the most important part of the work, both for the beginner and experienced electroencephalographer. It offers an opportunity to evaluate once more in the light of their experience the diagnostic possibilities and limitations of EEG. When one reviews critically the presented material from the standpoint of an individual EEG diagnosis, 4 main conclusions emerge: (1) The presence of a normal record constitutes an argument of considerable weight both against the diagnosis of a gliomatous or metastatic supratentorial tumor or brain abscess. (The incidence of normal records is 7—14% in patients with these disorders.) It would also constitute the same argument against the diagnosis of idiopathic epilepsy (incidence, 11% according to the authors). However, in view of the controversial definition of idopathic epilepsy, a more conservative figure of 24% found by the authors in combined idiopathic and symptomatic epilepsy seems to be more acceptable, particularly as they have not made systematic use of "activating" procedures. Conversely, the presence of an abnormal record would rule out the diagnosis of psychoneurosis. Presumably this does not apply to obsessive-compulsive cases and those with "encephalo syncopes" (classified with epilepsies). (2) Whenever focal abnormality appears in patients with focal lesion of the convexity, whatever the etiology may be, the localizing value of EEG is very high. (3) The presence of a spike-wave pattern characterizes convulsive disorders but occurs only in about 20% of epileptic patients. (4) The finding of any other type of abnormality considered in itself, although occurring with different frequencies in various clinical conditions, does not permit one to make any specific clinical diagnosis.

The last finding is familiar to every experienced electroencephalographer but much less so to the clinicians. The work of Strauss *et al.* offers a statistical basis for its validity. For instance, in a differential diagnosis between the supratentorial gliomas and the vascular lesions, the presence of a normal record or of a record characterized by a marked asymmetry of alpha rhythm, favors a vascular etiology. However, if one faces an abnormal record with delta activity, statistical differences of incidence of various types of abnormality are not sufficient to make an individual diagnosis. Thus focal abnormalities are found in 66% of the abnormal records in patients with cerebral thrombosis and in 80% of abnormal records in patients with supratentorial space-occupying lesions regardless of the type. Corresponding figures for high degree focal abnormalities are 20% for the cerebral thromboses, 35% for supratentorial meningiomas, and 66% for supratentorial gliomas and metastases.

In inflammatory diseases of the brain, asymmetrical focal abnormalities are found in about 25% of the abnormal records taken from patients with meningitis and meningoencephalitis as against 40% in brain abscesses, the differential diagnosis therefore being difficult. Diffusely abnormal records are found in 16% of the referred cases with systemic infectious diseases, 30% of the cases with cardiovascular disorder (with failure), 10% in diseases of the lungs (with cyanosis), all presumably without cerebral pathology. One may compare with these

figures the total incidence of abnormal records in cerebral disorders: in luetic encephalopathy, about 30%; multiple sclerosis, 6%; congenital diffuse cerebral defects, without epilepsy, 45%; acute encephalitis, 67%; and chronic epidemic encephalitis, 20%.

Records with bursts of delta activity are found with equal frequency—about 50% of all cases—in either aqueductal glioblastomas or idiopathic epilepsy; also, with lower incidence, (10-20%), in cerebellopontine tumors, dystonia, meningovascular lues, narcolepsy, congenital encephalopathy with convulsions, and in behavior disorders of children and adolescents. Generalized bursts of spike-and-waves are found in 12% of cases with grand mal epilepsy, 25% of cases with petit mal epilepsy, and 13% of cases with a diffuse congenital cerebral defect (with seizures).

The reviewer puts emphasis on these findings, which illustrate the difficulties of an individual EEG diagnosis; one must be deeply indebted to the authors who, without overstressing this point, have rendered a public service by showing in their *Diagnostic Epilepsy* these fundamental diagnostic limitations of EEG. Obviously there is room for further progress through a wider application of activation techniques and of a more painstaking differentiation of the distribution of the focal pattern on the surface of the head in cases with vascular and space-occupying lesions. It remains that the diagnostic possibilities of the EEG are subordinated to a complete clinical appraisal of the patient's condition. Only then, what represents a mere statistical probability on the basis of the authors' tables may become a quasi certitude in the light of the clinical picture, and vice versa.

The authors conclude by stressing once more the importance for the electroencephalographer to be informed about the specific diagnostic problem presented by the patient referred to him and express their hope that their monograph, by showing what the electroencephalographer can and cannot do, will contribute to a better integration of EEG into the total practice of medicine.

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THE PSYCHOPATHIC DELINQUENT AND CRIMINAL. By *George Thompson, M.D.* (Springfield: C. C. Thomas, 1952.)

This little volume is ambitious in its scope. It is described by its author as "an attempt to apply the scientific method of statistical evaluation to large numbers of cases" and as "an attempt at complete objectivity and freedom from inhibitions resulting from acceptance of 'authorities'." When one views this effort objectively, it is apparent that methodologically it falls far short of its author's mark. It is anything but scientific. Surely, in a study in which the hypotheses are so novel and unorthodox, one has the right to ask for carefully presented factual data in their support. These are either wholly lacking or so sketchily presented as to be nearly valueless.

In the chapter entitled "The Evidence," we have such unsupported statements as "psychopathic personalities often appear to develop in the most wholesome environments," and "we see numerous examples" of normal individuals developing into psychopaths following cerebral trauma. In order to support the thesis that organic injury to the nervous system plays a prominent role in the production of psychopathy, there is an incidence table of "Neurological Signs Found Among 280 Delinquents," in which are listed such vague and tenuous data as "altered deep reflexes, pathological reflexes, altered superficial reflexes, abnormality of cranial nerves, associated glandular and other physical disorders, and left handedness."

The author's definition of "psychopathic personality" is a very loose one: "that personality deviation characterized by an inability of the afflicted person to adjust adequately and consistently to social standards." The basic physiopathology is postulated as "malfunctioning engrammes in diencephalic-cortical pathways, permitting periodic releases of discharges from diencephalic centers to manifest themselves through abnormal pathways into the cortex." This is produced by 2 factors in every case, "psychogenesis and cerebral injury, which may be of any type whatsoever as long as it adequately disrupts the neuronal pattern basic to personality function." The organic factor may also be hereditary, of a "recessive genotype mode of inheritance." The author conceives of the basic personality defect of the psychopath not as his inability to form meaningful and satisfying relations with others but "an inability to develop an adequate concept of time, particularly with regard to self." The book does not satisfactorily explain this concept, but apparently it is held to be the chief factor behind the psychopath's inability to postpone immediate gratification and his inability to learn by experience. In further explanation of this theory, the author makes the very pessimistic and, I trust, inaccurate observation: "A review of almost anyone's past is likely to bring to him a sense of depression—to almost anyone but a psychopath."

Although the author observes that psychotic episodes in the psychopath are evanescent, he advocates the use of either electroshock or insulin shock in their treatment. He believes that chemotherapy, chiefly with phenobarbital and dilantin, is the best treatment for the basic psychopathic disorder, but foresees the time when psychosurgery will be the chief therapeutic agent.

Many of the author's assumptions, which he apparently believes to be shared by fellow workers, are open to serious question, e.g. that manic-depressive insanity is a common cause of alcoholism and "therefore contributes in marked degree to the incidence of the so-called cases of psychotic delinquence," that pathological alcoholic intoxication and psychomotor epilepsy are in many instances indistinguishable, that a high degree of autoerotism is found among "patients with the epileptoid personality syndrome," etc.

This book on the psychopathic criminal has considerably more value than De River's book on the

sexual criminal, a piece of charlatanry with special appeal to sado-masochists, brought out recently by the same publisher. At least, Dr. Thompson presents some interesting speculations, but unfortunately they are unsupported by adequate data.

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SPEZIELLE PATHOLOGIE DER KRANKHEITEN DES ZENTRALEN UND PERIPHREN NERVENSYSTEMS. By *Gerd Peters.* (Stuttgart: Georg Thieme Verlag, 1951.)

This German textbook gives in a concise manner a comprehensive account of the pathology of the central and peripheral nervous system, including most of the rarer conditions. Of particular value are the introductions to the larger subdivisions which offer a general survey over the subject before the individual diseases are discussed, similarly the conclusions following some of the chapters. Discussions of the pathogenesis help the understanding of the disease process. Discussion of the clinical pictures is generally kept very short but a fairly extensive chapter deals with the hypothalamic-hypophyseal syndrome. The illustrations, which were intentionally reduced to keep the price of the book low, are adequate.

This book will be interesting to the pathologist as well as to the neurologist and psychiatrist, especially since much of the literature is drawn from German sources which might not be familiar to all readers on this continent.

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FUNDAMENTAL CONCEPTS IN CLINICAL PSYCHOLOGY. By *G. Wilson Shaffer and Richard S. Lazarus.* (New York: McGraw-Hill, 1952. Price: $6.00.)

Shaffer and Lazarus describe their book as "an effort to present a systematic and integrated group of topics that are fundamental to satisfactory movement in the clinical field. The emphasis of the book is placed on theory and methodology and is therefore directed both to the beginning student in clinical psychology and to the person who has developed some competence with clinical techniques."

In the first chapter the authors attempt to present in 31 pages the historical background of clinical psychology, its current status and professional problems. An excellent chapter on methodology follows this necessarily superficial survey.

The next 5 chapters deal with the nature and measurement of intelligence and personality. Throughout this section clinical psychologists are reminded of their responsibilities for research that will correct and enlarge their concepts of personality dynamics and of the need to examine their premises if such research is to be effective. A review of the most widely used tests of intellectual functioning follows with some consideration of the effects upon their construction of different theoretical views of the nature of intelligence.

The authors conclude that although the important theoretical approaches to the nature of personality differ in terminology, their concepts are quite similar, and that it probably does not matter whether one prefers the psychoanalytic or the stimulus-organism-response theories. The efforts of Mowrer, Dollard, Miller, and others to reconcile these 2 appoaches are barely mentioned.

Surprisingly little attention is paid to the problems of unconscious motivation nor is there any suggestion that they might be studied by research methods. It is rather grudgingly admitted that "almost all clinical psychologists assume, at least, that human behavior may be determined by processes of which the individual is totally or partially unaware." The projective tests are described as a product of the depth psychologists "who choose to understand behavior in terms of complex motivations (many of which are considered to be unconscious.)" The projective approach to the study of personality is, however, considered valid since laboratory research demonstrates that a subject's needs will affect what he perceives. Special attention is given to the need for research to validate and improve the main projective tests. The tendency to introduce new projective techniques with virtually no information to substantiate their value is adequately deplored. This section of the book, while a thorough and stimulating discussion, is to some extent marred by a rather irritable quality in the chapter on projective tests, occasional mixed metaphors, and the use of the term "personologist" which it is to be hoped will not be generally adopted.

Of the remaining 7 chapters 5 are devoted to the description of major theories and techniques of psychotherapy, one to physical and chemical therapies and the last to "the clinician in action." The tone of the book changes sharply at this point. In the chapters on psychotherapy there is little of the emphasis on research that characterizes the treatment of other topics. However, there is an obvious attempt to inform the beginner of methods of psychotherapy other than Freudian psychoanalysis and nondirective counseling. The work of Adolph Meyer here receives attention which is unfortunately rare in texts addressed to psychologists. The chapter on the physical and chemical therapies is brief. Studies made by psychologists to aid in evaluating these types of treatment are mentioned rather than reviewed. The last chapter considers briefly the psychologist's role in teaching, training, research, and clinical practice in various types of institutions. The book closes with 5 case histories that include quite complete reports of psychological examinations.

Though this book might be used to introduce beginning graduate students to clinical theory and practice, it is likely to be of most value to advanced graduate students or professional workers who wish to organize their information on personality and intellectual functioning.

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PHEOCHROMOCYTOMA AND THE GENERAL PRACTITIONER. By *Joseph L. DeCourcy, M.D., and Cornelius B. DeCourcy, M.D.* (Cincinnati: DeCourcy Clinic, 1952.)

The purpose of this book is to draw to the attention of everyone, and especially the general practitioner, that the presence of a pheochromocytoma should be considered in every case of essential hypertension. The authors do not mean, of course, that it is very common but to miss one is. They address the book, naturally, to the general man in practice because he sees so many people with essential hypertension of the ordinary varieties that he is in a more vulnerable position psychologically than the specialist who is more usually in touch with the unusual and the rare, and these things are closer to the surface of his consciousness. Nevertheless, it is a book that everyone can profit by. They emphasize that pheochromocytoma is a "great mimic" among hypertensive disorders, and short statements from many writers illustrate this truth.

The clinical symptoms and signs that make one suspect the condition as well as those of the most typical cases are very clearly described and examples are given without skimping. The all-important means of confirming the suspicion and the older and newer methods are gone into thoroughly. The difficulties and dangers of some of the older tests and the points that confuse the issue are considered carefully as by those who know how difficult it is to be sure of interpretation of any tests that are easy to describe in books. The tests that has proved of real value are carefully detailed. Mistaken diagnosis such as psychoneurosis, thyreoid disease, etc., are depicted in case histories. These are of value because of the care taken to show that the mistakes were apparently reasonable, like those many of us have made. The pathology and physiology of adrenal medullary tumors in general, and pheochromocytoma in particular, are described and the explanation and description of individual symptoms that this tumor produces are analyzed in an interesting and really helpful way. Finally, the surgical considerations occupy the last chapter and the personal experience of the authors is obvious. The bibliography contains some 361 references. Although the book is not large, it is most interestingly and accurately written and therefore valuable. It achieves its purpose.

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CYBERNETICS. Transactions of the Eighth Conference, 1951; Transactions of the Ninth Conference, 1952. Edited by *Heinz von Foerster.* (New York: Josiah Macy, Jr. Foundation, 1952, 1953. Price: $4.00 per volume.)

These 2 volumes embody the papers presented in 2 additional conferences in which the Macy Foundation attempts to extract as valuable data as it can from the assembly of scholars from diverse disciplines on the subject of cybernetics. Among the noteworthy contributions of the 1951 volume may be mentioned the experiment described by Alex Bavelas (economics, social science, Massachusetts Institute of Technology) at the 1951 conference. In this experiment, several "communications networks" were set up with groups of people undertaking a simple task: determining which symbol is common to a number of cards when each person sees only 1 card. They communicate by sending written messages along pathways designated by the given pattern, as: in a circle; radially to and from a central person; along a line. From this apparently fruitless, simple game there are astonishing developments: a more or less successful effort by the subjects to deduce the configuration of the network in which they are; the emergence of a kind of leadership at one position; sharp differences in morale and (inversely) in efficiency, with aggressiveness or apathy leading some of the people to play games or tear up the messages instead of trying for a solution. It is shown that the extent of information about such a "social relation" and degree of confidence in the information affect the tolerability of the relation, and that information that seems meaningful in one part of a relation may be useless to the recipient.

On more familiar ground, Kubie relates some personal and clinical experiences with partly conscious communication, with hypnosis, and with unconscious memory. Claude Shannon (Bell Telephone Laboratories) of the mechanical chess-player describes a machine that can learn to solve a maze.

The 1952 conference begins with Gregory Bateson on humor (as at least a nominal topic from which to study communication more broadly) and then includes a categorization of feedback supposedly entering into emotion, effects of lobotomy on the octopus, and growth of a sort of helmet in a crustacean. "Homeostatis" is restated in primitive mathematical terms by an English student who has actually perfected a machine called a "homeostat."

When Kubie tells of his 80-year-old patients who face problems dating from the age of 4; when the English scientist explains that a through-and-through circular system, like the brain, can be connected either normally or in reverse to its effectors, then fundamental attitudes and information of a cogent sort are being exchanged and something is bound to follow, given time. The concept of the *black box,* a mechanism unspecified with only the input and output known (the human brain being subject to this kind of consideration), continues to appear and is valuable.

But 9 conferences have not shaken off some of the misconceptions that embarrass "cybernetics." Aside from a persistently airy use of terms, there is no doubt that misapplication of the idea of feedback, circular systems or reverberation, etc. is the most serious handicap faced by these conferences, the one most uniform source of muddling. W. S. McCulloch, as chairman, is distinguished for judicious management of 30 geniuses, and even more for citing old and new experimental findings ingeniously pertinent to the discussion. It is regrettable, however, that not even he can exact cogency

when "feedback" is tossed about so loosely.

All these efforts may be looked upon as painful attempts to bring into cybernetics some clearly focused light from contemporary science. Valuable as these attempts are, it appears that this clear focus still eludes us, and will do so for some years to come.

H. A. La Burt, M. D.,
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Conversation and Communication. By *J. A. M. Meerloo.* (New York: International Universities Press, 1952. Price: $4.00.)

This book merits only the briefest review. It is not a rational or scientific discussion of conversation and communication, and its amorphous content can scarcely be epitomized. The general thesis is that language is not a product of the conscious intelligence, but rather of the dark and devious processes of the libidinous unconscious, an oral-anal exercise which neither says what it means nor means what it says. The work contains certainly much that is true, sometimes arrestingly stated, but little that is new. It is full of psychoanalytic poeticisms, undemonstrable assumptions, and fanciful conceits. The imagery, often rich, varies from the scatological to the esoteric. For example:

"Stuttering is the letting out and keeping in of words, accompanied by an internal play with the emotional concepts involved. The result is a confusing 'word constipation.' Yes, truly a constipation—for the guilty, civilized, neurotic words are sometimes unconsciously compared to and associated with dirt, feces. . . . . Here we may speak of a real anal language" (p. 48-9).

"[Even when speaking nonsense] we are warmed and delighted because we are together in a play without rules. A feeling of comfort and well-being steals over us, a notion of being safe and well defended. We are caught up in the ecstasy of life that became word" (p. 239).

The book will afford amusement and instruction to the layman. It offers but little to the serious and informed reader.

Roland P. Mackay, M. D.,
Chicago, Ill.

Second Annual Report on Stress. By *Hans Selye and Alexander Horava,* (Montreal: Acta, Inc., 1952.)

Professor Selye has collaborated with Dr. Horava in the preparation of a *Second Annual Report on Stress.* This volume has even more of the features of an extensively cross-referenced bibliography than had the First Annual Report. The first 29 pages are devoted to a description of bibliographical methods used in the book and in answering comments and criticisms of previous publications by the senior author. A list of neologisms and definitions, and a discussion of the more general features of the physiology and pathology of stress take up about 15 pages. The remainder of the book is given over to detailed, systematic reference lists of the relationships of metabolic systems and particular organs to various types of stress. The descriptive text is very brief indeed, so that its value lies in facilitating "the task of finding specific information on any one probelm." One hundred and seventy-five pages of references with titles, that were not included in the previous volumes, are followed by the index.

The purpose of the book is to be an index and guide to recent literature in this wide field. *The Second Annual Report on Stress* fulfills this purpose and will be of undoubted value as a reference work.

E. A. Sellers, M. D.,
Department of Physiology,
University of Toronto.

Psychology. By *Ross Stagner and T. F. Karwoski.* (New York: McGraw-Hill, 1952. Price: $5.00.)

This volume is written as a textbook for the beginning student in college courses in psychology. Psychology is defined here as the study of human behavior and experience and the frames of reference for the book are scientific, experimental, and biological. There are 3 main sections to the text—dynamics, cognition, and personality. Under dynamics are considered biological drives, emotions, and social motives; under cognition, sensing, perceiving, association, conditioning, problem solving, remembering, thinking, and intelligence; under personality, foundations, conflict, and maturity. The last 3 chapters might be expected to be of the most interest to psychiatrists. Yet of necessity in a book of such broad range only passing reference can be given to psychiatric theory and fact and, unfortunately, in such a sketchy manner as to be somewhat misleading. For example, the authors write: "a neurosis is a form of personality disturbance serious enough to make it difficult for the person to carry on his usual activities, but not serious enough to require institutionalization, [while] a psychosis is a breakdown which involves loss of contact with reality and, consequently, the possibility of behavior harmful to the individual himself or to others, hence usually requiring care in a hospital." Such deficiencies may be excused in view of the broad coverage of the book. It would probably be more of value to psychiatrists to read the earlier chapters of such a book as this from time to time to keep abreast of the developments in psychology.

Paul E. Huston, M. D.,
Iowa City, Iowa.

IN MEMORIAM

ROBERT GAUPP[1]

1870-1953

The news has reached us that Prof. Robert Gaupp, the outstanding and internationally known psychiatrist, died on August 30, 1953, at the age of 82, in Stuttgart, Germany, where for some years he had been living in retirement.

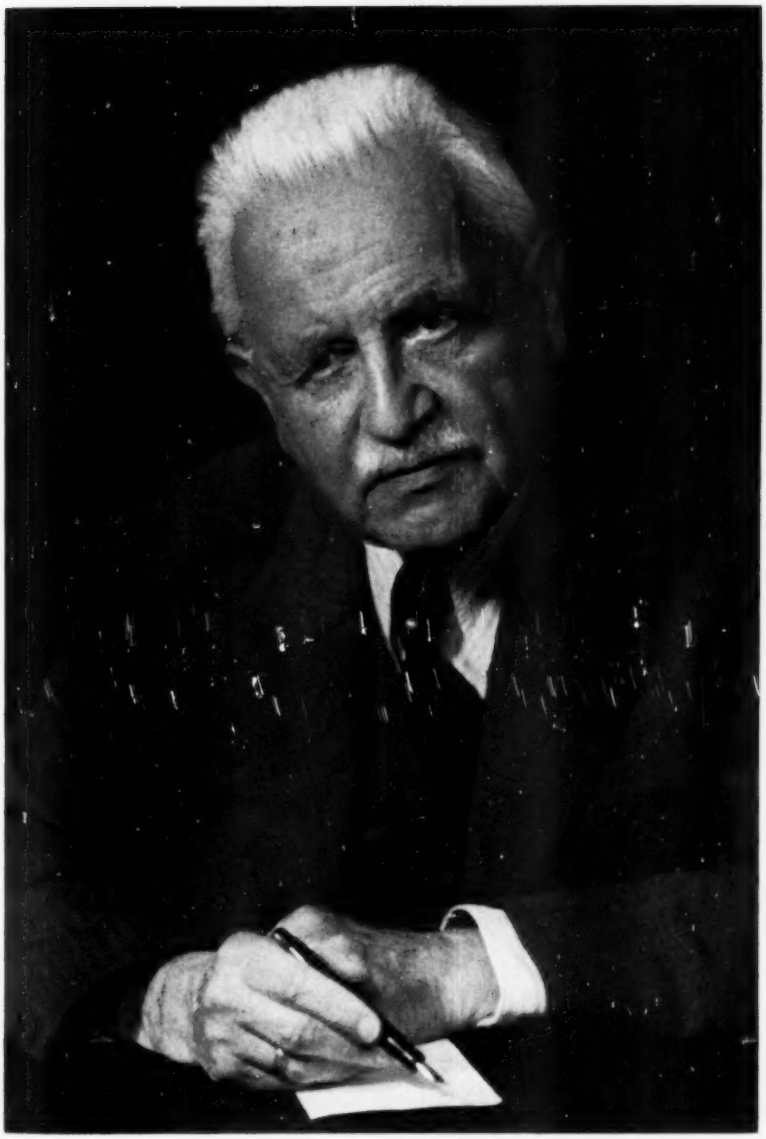
He had studied with Wernicke in Breslau and worked with Kraepelin in Heidelberg and Munich before he went to Tübingen, where he held the chair in psychiatry and directed the Psychiatric Clinic from 1906 to 1936. He continued Kraepelin's work but also developed new lines of investigation and made valuable contributions to the problem of individual character and psychosis. Gaupp had a remarkable, all-round personality and was interested not only in psychiatry but also in the border sciences related to psychiatry. Among his numerous and valuable books and papers is the extraordinary study on the mass murderer Wagner (1913), which offered for the first time a different and highly significant outlook on personality and psychosis. Gaupp was an efficient therapist and a great teacher. A large number of his pupils—Kretschmer, Reiss, Storch, Kurt Schneider, and Brodmann—published their first papers at his clinic and under his guidance.

After his retirement in 1936 he remained active and interested in everything that was going on in psychiatry, in Germany and abroad as well. He continued to make contributions to psychiatric literature, among them: *Von der Ethick des Arztes* (On Doctors' Ethics) and the important *Letter to Karl Jaspers* on the occasion of his seventieth birthday. In this letter, which was published in *Medizenische Klinik*, February 20, 1953. Gaupp gives an appreciative outline of Jaspers' lifework, with particular regard to the changes that Jaspers made in the successive editions of his *General Psychopathology*. He was a great admirer of Jaspers and paid unqualified tribute to the younger man whom he hailed as the rare type of philosopher-psychiatrist and as a guiding spirit in the "exact, profound, and highly responsible cogitive study of general psychopathology."

Gaupp's plan to write a history of European psychiatry has, regrettably, remained unfinished. He leaves a lasting influence on German psychiatry and will be remembered with gratitude and affection by his pupils and friends all over the world. He has been rightfully regarded in these latter days as the Grand Old Man of German Psychiatry.

WILLIAM MAYER, M. D.

[1] The accompanying photograph of Prof. Gaupp was taken in 1950 on his eightieth birthday.



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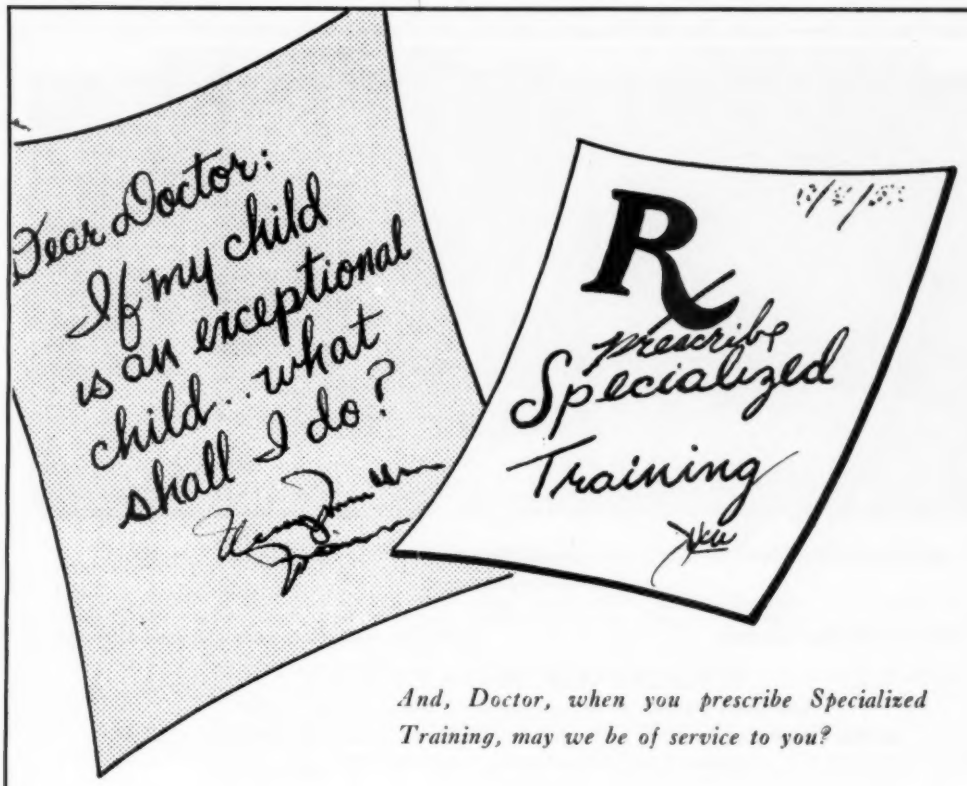

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